Application No.: 11665271

Contract No.: Leave this blank

La Capitale
Insurance and
Financial Services

March 2014
version

Application

Life Insurance and Critical Illness Insurance

T073 (02-2014)

La Capitale

Application No.: 11665271

1. BASIC INFORMATION

Language of correspondence: ☐ English ☐ French

Indicate if this is: ☐ a new application **OR** ☐ an amendment to existing contract No.: _____

Related applications

The following applications are related.

Last name of insured(s)	First name of insured(s)	Application No.

☐ Check if you would like these contracts to be issued at the same time.

2. INSUREDS' INFORMATION

If there are more than 2 insureds, use as many extra application forms as necessary. On each extra application form, replace the Application No. with the number of the initial application. **Submit all related applications together.**

	INSURED 1	INSURED 2
	Last name	Last name
	First name	First name
	Last name at birth / Marital status	Last name at birth / Marital status
	Date of birth (YYYY/MM/DD) / Gender ☐ Male ☐ Female	Date of birth (YYYY/MM/DD) / Gender ☐ Male ☐ Female
	Place of birth: Province / Country	Place of birth: Province / Country
	S.I.N.	S.I.N.
	Permanent resident of Canada? ☐ Yes ☐ No / In Canada since	Permanent resident of Canada? ☐ Yes ☐ No / In Canada since
Address	No., street / Apt.	No., street / Apt.
	City / Province	City / Province
	Country / Postal code	Country / Postal code
	Area code Home tel.	Area code Home tel.
Information about employment **Must be completed**	Occupation	Occupation
	Name of employer	Name of employer
	Area code Work tel. (ext., if applicable)	Area code Work tel. (ext., if applicable)
	No., street	No., street
	City	City
	Province / Postal code	Province / Postal code
	Salary $ / Commission $	Salary $ / Commission $
	Bonus $ / Other income $	Bonus $ / Other income $
	Source of other income	Source of other income
	Total assets (real estate, equity capital in companies, stocks, bonds, etc.) $	Total assets (real estate, equity capital in companies, stocks, bonds, etc.) $
	Total liabilities (mortgages, loans, etc.) $	Total liabilities (mortgages, loans, etc.) $
Verification of identity 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.	**ID** (use original documents only) ☐ Birth certificate ☐ Driver's licence ☐ Passport ☐ Health insurance card	**ID** (use original documents only) ☐ Birth certificate ☐ Driver's licence ☐ Passport ☐ Health insurance card
	Document No.	Document No.
	Province or country of issue	Province or country of issue

La Capitale

3. POLICYHOLDER'S INFORMATION

(Complete the applicable section depending on the policyholder's status as a natural person or a company)

THE POLICYHOLDER IS A NATURAL PERSON

The policyholder is:
- ☐ Insured 1 only
- ☐ Insured 2 only
- ☐ Insureds 1 and 2 *

} Proceed to Section 3.3.

- ☐ Other (Complete Sections 3.1, 3.2 and 3.3)

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

3.1. POLICYHOLDER'S INFORMATION

Last name _____ First name _____

Marital status _____ Gender ☐ Male ☐ Female

Relationship to insured _____ Date of birth (YYYY/MM/DD) _____

Occupation _____ S.I.N. _____

No., street _____ Apt. _____

City _____ Province _____

Country _____ Postal code _____

Area code Home tel. _____ Area code Work tel. (ext., if applicable) _____

3.2 VERIFICATION OF POLICYHOLDER'S IDENTITY

ID (use original documents only)

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

Document No.: _____

Province or country of issue: _____

3.3 THIRD PARTY DETERMINATION

Is the policyholder acting in accordance with the instructions of another person (third party)?

☐ Yes ☐ No **If so, provide the following information about the third party:**

Last and first name of third party		Date of birth (YYYY/MM/DD)
Relationship to policyholder	Occupation or key activity	
Address (No., street, apt.)		
City	Province	Postal code

If the third party is a company: Corporation No.: _____

Place of incorporation: _____

4. SUBROGATED POLICYHOLDER

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

Date of birth (YYYY/MM/DD) _____ Gender ☐ Male ☐ Female

Relationship to policyholder _____ S.I.N. _____

5. PURPOSE OF INSURANCE

Must be completed

- ☐ Personal insurance
- ☐ Business insurance
  - How was the amount of insurance determined?
    - ☐ Key person
    - ☐ Buy out associates/redeem shares
    - ☐ Creditors
    - ☐ Other: _____

THE POLICYHOLDER IS A COMPANY

3.1. POLICYHOLDER'S INFORMATION

Company name _____

No., street _____ City _____

Province _____ Postal code _____

Name and title of authorized signatories:* _____

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

3.2 VERIFICATION OF POLICYHOLDER'S IDENTITY

Complete the Identity Verification – Corporations and Other Entities form available in the illustration software.

Corporation No.: _____

Place of incorporation: _____

3.3 THIRD PARTY DETERMINATION

Is the policyholder acting in accordance with the instructions of another person (third party)?

☐ Yes ☐ No **If so, provide the following information about the third party:**

Name of third party		Date of birth (YYYY/MM/DD)
Relationship to policyholder	Occupation or key activity	
Address (No., street, apt.)		
City	Province	Postal code

If the third party is a company: Corporation No.: _____

Place of incorporation: _____

4. SUBROGATED POLICYHOLDER

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

Date of birth (YYYY/MM/DD) _____ Gender ☐ Male ☐ Female

Relationship to policyholder _____ S.I.N. _____

5. PURPOSE OF INSURANCE

Must be completed

How was the amount of insurance determined?

- ☐ Key person
- ☐ Buy out associates/redeem shares
- ☐ Creditors
- ☐ Other: _____

Identify the company's key activities: _____

Insured 1's percentage of company shares: _____ %

Insured 2's percentage of company shares: _____ %

Company's assets: $ _____ Company's liabilities: $ _____

Net worth: $ _____ Fair market value: $ _____

Net profit: Current year $ _____

Previous year $ _____

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6. CHOICE OF COVERAGE

Separate contracts will be issued for Universal Life Insurance and Critical Illness insurance products.

MAIN COVERAGE

	INSURED 1	INSURED 2
Permanent Life Insurance ***Non-participating Permanent Advantage*** * The premium payment period varies according to the insured's age. Refer to the illustration and the contract.	☐ **Individual** – Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 (minimum 25 years) ☐ for life ☐ **Joint** – Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 (minimum 25 years)* ☐ for life ☐ Insured amount payable on first-to-die basis ☐ Insured amount payable on last-to-die basis, premiums payable until 1st death ☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death **Insured amount: $** _____	☐ **Individual** – Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 (minimum 25 years) ☐ for life ☐ **Joint** – Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 (minimum 25 years)* ☐ for life ☐ Insured amount payable on first-to-die basis ☐ Insured amount payable on last-to-die basis, premiums payable until 1st death ☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death **Insured amount: $** _____
100% Pure Evolvement	☐ **Individual** ☐ **Joint** ☐ Insured amount payable on first-to-die basis ☐ Insured amount payable on last-to-die basis, premiums payable until 1st death ☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death **Insured amount: $** _____	☐ **Individual** ☐ **Joint** ☐ Insured amount payable on first-to-die basis ☐ Insured amount payable on last-to-die basis, premiums payable until 1st death ☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death **Insured amount: $** _____
100% Pure Protection	☐ **Individual** ☐ Critical Illness Option (not available with joint life insurance) ☐ **Joint** ☐ Insured amount payable on first-to-die basis ☐ Insured amount payable on last-to-die basis, premiums payable until 1st death ☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death **Insured amount: $** _____	☐ **Individual** ☐ Critical Illness Option (not available with joint life insurance) ☐ **Joint** ☐ Insured amount payable on first-to-die basis ☐ Insured amount payable on last-to-die basis, premiums payable until 1st death ☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death **Insured amount: $** _____
Term Life Insurance **Fixed Term**	☐ 10 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years ☐ **Individual** ☐ **Joint first-to-die** **Insured amount: $** _____	☐ 10 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years ☐ **Individual** ☐ **Joint first-to-die** **Insured amount: $** _____
20.10 Protection	☐ **Individual** ☐ **Joint first-to-die** **Insured amount: $** _____	☐ **Individual** ☐ **Joint first-to-die** **Insured amount: $** _____
Decreasing term	☐ 15 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years ☐ **Individual** ☐ **Joint first-to-die** **Insured amount: $** _____	☐ 15 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years ☐ **Individual** ☐ **Joint first-to-die** **Insured amount: $** _____
The Provider *Monthly income for your loved ones* The policyholder must be a natural person. Not available with *Life Saver*.	☐ 15 years ☐ 20 years ☐ 25 years ☐ **Fixed term** ☐ **Decreasing term** **Monthly insured amount: $** _____	☐ 15 years ☐ 20 years ☐ 25 years ☐ **Fixed term** ☐ **Decreasing term** **Monthly insured amount: $** _____

6. CHOICE OF COVERAGE (cont.)

MAIN COVERAGE (cont.)

	INSURED 1	INSURED 2
Universal Life Insurance ***Life Saver*** *** The premium payment period varies according to the insured's age. Refer to the illustration and the contract.** Attach the illustration signed by the policyholder.	☐ **Individual** – Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 (minimum 25 years) ☐ for life ☐ **Joint** – Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 (minimum 25 years)* ☐ for life ☐ Insured amount payable on first-to-die basis ☐ Insured amount payable on last-to-die basis, premiums payable until 1st death ☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death **Insured amount: $** _____ **Investment instructions** Liquidity account _____ % 3-year GIC _____ % 5-year GIC _____ % 10-year GIC _____ % Canadian Equity _____ % American Equity _____ % International Equity _____ % Canadian Bonds _____ % Canadian Equity (Dynamic) _____ % American Equity (Dynamic) _____ % Canadian Balanced (Dynamic) _____ % Global Equity (Dynamic) _____ % Canadian Dividend (AGF) _____ % Global Balanced (AGF) _____ % Conservative Profile (NBSI) _____ % Moderate Profile (NBSI) _____ % Balanced Profile (NBSI) _____ % Growth Profile (NBSI) _____ % Aggressive Profile (NBSI) _____ % **Total: 100%** **Tax strategy:** ☐ Notice of assessment ☐ Health and estate ☐ No strategy **Periodic savings premium:** ☐ Optimal savings premium based on selected strategy: ☐ Savings premium based on selected method of payment: ☐ Annual $ _____ ☐ Monthly $ _____ **Additional savings premiums:** (cash deposit): $ _____	☐ **Individual** – Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 (minimum 25 years) ☐ for life ☐ **Joint** – Premium payable: ☐ for 10 years ☐ for 15 years ☐ for 20 years ☐ to age 65 (minimum 25 years)* ☐ for life ☐ Insured amount payable on first-to-die basis ☐ Insured amount payable on last-to-die basis, premiums payable until 1st death ☐ Insured amount payable on last-to-die basis, premiums payable until 2nd death **Insured amount: $** _____ **Investment instructions** Liquidity account _____ % 3-year GIC _____ % 5-year GIC _____ % 10-year GIC _____ % Canadian Equity _____ % American Equity _____ % International Equity _____ % Canadian Bonds _____ % Canadian Equity (Dynamic) _____ % American Equity (Dynamic) _____ % Canadian Balanced (Dynamic) _____ % Global Equity (Dynamic) _____ % Canadian Dividend (AGF) _____ % Global Balanced (AGF) _____ % Conservative Profile (NBSI) _____ % Moderate Profile (NBSI) _____ % Balanced Profile (NBSI) _____ % Growth Profile (NBSI) _____ % Aggressive Profile (NBSI) _____ % **Total: 100%** **Tax strategy:** ☐ Notice of assessment ☐ Health and estate ☐ No strategy **Periodic savings premium:** ☐ Optimal savings premium based on selected strategy: ☐ Savings premium based on selected method of payment: ☐ Annual $ _____ ☐ Monthly $ _____ **Additional savings premiums:** (cash deposit): $ _____
For lump sum deposits of $100,000 or more, complete the form entitled "Identification of Politically Exposed Foreign Persons" available in the illustration software.		
Critical Illness **Extended coverage** For ***Simplified*** *Second Chance*, use the specific application form.	**Premium payable:** ☐ **In 15 instalments** ☐ **Until age 65** ☐ **Until expiry** **Insured amount: $** _____ ☐ **Reimbursement of premiums on death** ☐ **Reimbursement of premiums on surrender or expiry** If premiums are payable until expiry, choose the time when the percentage of reimbursement of premiums on surrender or expiry will be equal to 100% of premiums paid. Certain conditions apply. ☐ 15-year term ☐ on expiry	**Premium payable:** ☐ **In 15 instalments** ☐ **Until age 65** ☐ **Until expiry** **Insured amount: $** _____ ☐ **Reimbursement of premiums on death** ☐ **Reimbursement of premiums on surrender or expiry** If premiums are payable until expiry, choose the time when the percentage of reimbursement of premiums on surrender or expiry will be equal to 100% of premiums paid. Certain conditions apply. ☐ 15-year term ☐ on expiry
Children's Critical Illness Please complete additional questionnaire B4, "Children's Critical Illness" on page 29.	**Insured amount: $** _____ ☐ Health Option	**Insured amount: $** _____ ☐ Health Option
☐ **Other**	_____ _____ _____	_____ _____ _____

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6. CHOICE OF COVERAGE (cont.)

ADDITIONAL BENEFITS AND RIDERS

	INSURED 1	INSURED 2
	☐ **Accidental Death and Dismemberment: $** _____ (Not available with *The Provider, Monthly income for your loved ones*, joint last-to-die plans or critical illness)	☐ **Accidental Death and Dismemberment: $** _____ (Not available with *The Provider, Monthly income for your loved ones*, joint last-to-die plans or critical illness)
	☐ **Guaranteed Insurability: $** _____ (Not available with *The Provider, Monthly income for your loved ones*, term life insurance or critical illness)	☐ **Guaranteed Insurability: $** _____ (Not available with *The Provider, Monthly income for your loved ones*, term life insurance or critical illness)
Complete additional questionnaire B5, "Disability Income Benefit" on page 30.	☐ **Monthly Disability Income: $** _____ (Not available with joint-last-to-die plans, critical illness or if the policyholder is a company) **Duration of coverage:** ☐ 20 years ☐ 25 years ☐ 30 years **Maximum period of benefit payments:** ☐ 2 years ☐ 5 years ☐ Until expiry	☐ **Monthly Disability Income: $** _____ (Not available with joint-last-to-die plans, critical illness or if the policyholder is a company) **Duration of coverage:** ☐ 20 years ☐ 25 years ☐ 30 years **Maximum period of benefit payments:** ☐ 2 years ☐ 5 years ☐ Until expiry
If the policyholder is not Insured 1 or Insured 2, complete Section A "Medical and non medical information".	☐ **Waiver of premiums (WP)** (Not available if the policyholder is a company or if there is more than one policyholder) ☐ **Disability of policyholder** ☐ **Disability or death of policyholder** (Not available with joint plan)	☐ **Waiver of premiums (WP)** (Not available if the policyholder is a company or if there is more than one policyholder) ☐ **Disability of policyholder** ☐ **Disability or death of policyholder** (Not available with joint plan)
	☐ **Renewable and Convertible Fixed Term rider** ☐ 10 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years (Not available with term life insurance or critical illness) **Insured amount: $** _____	☐ **Renewable and Convertible Fixed Term rider** ☐ 10 years ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years (Not available with term life insurance or critical illness) **Insured amount: $** _____
	☐ ***The Provider, Monthly income for your loved ones* rider** (Not available with *Life Saver*, 10-year fixed term life insurance, critical illness or if the policyholder is a company) ☐ 15 years ☐ 20 years ☐ 25 years ☐ Fixed term ☐ Decreasing term **Monthly insured amount: $** _____	☐ ***The Provider, Monthly income for your loved ones* rider** (Not available with *Life Saver*, 10-year fixed term life insurance, critical illness or if the policyholder is a company) ☐ 15 years ☐ 20 years ☐ 25 years ☐ Fixed term ☐ Decreasing term **Monthly insured amount: $** _____
	☐ **Critical Illness rider** (Not available with *Life Saver*, critical illness or *100% Pure Protection* with Critical Illness Option) ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years **Insured amount: $** _____	☐ **Critical Illness rider** (Not available with *Life Saver*, critical illness or *100% Pure Protection* with Critical Illness Option) ☐ 20 years ☐ 25 years ☐ 30 years ☐ 35 years **Insured amount: $** _____
* The insured must be the child's father or mother, as indicated on the child's birth certificate or by virtue of legal adoption.	☐ ***Accidental Fracture* rider** ☐ 1 unit ☐ 2 units ☐ **Individual** ☐ **Individual with children***	☐ ***Accidental Fracture* rider** ☐ 1 unit ☐ 2 units ☐ **Individual** ☐ **Individual with children***
Complete additional questionnaire B6 , "Children's Life Insurance rider" on page 31.	☐ **Children's Life Insurance rider** (Not available with critical illness)	☐ **Children's Life Insurance rider** (Not available with critical illness)
Complete additional questionnaire B7, "Children's Critical Illness rider" on page 32.	☐ **Children's Critical Illness rider** (Not available with *Second Chance for Children*)	☐ **Children's Critical Illness rider** (Not available with *Second Chance for Children*)

7. DESIGNATION OF BENEFICIARY

Designating an irrevocable beneficiary can have significant consequences. To replace a beneficiary designated as irrevocable, or carry out certain changes or transactions, you must obtain the beneficiary's consent. 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.

If the policyholder lives in Quebec, and if the named beneficiary is the person to whom he or she 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.

Life insurance

Any designation of the "Estate" shall refer to the estate of the insured.

INSURED 1

	Last name	First name	Date of birth (YYYY/MM/DD)	Relationship to policyholder	Check one: Revocable	Check one: Irrevocable	Share % Total 100%
Beneficiary(ies)					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
Contingent					☐	☐	

INSURED 2

	Last name	First name	Date of birth (YYYY/MM/DD)	Relationship to policyholder	Check one: Revocable	Check one: Irrevocable	Share % Total 100%
Beneficiary(ies)					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
Contingent					☐	☐	

Critical illness

Do not designate a beneficiary for critical illness coverage, since the benefits are paid 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 designated otherwise in the application.

INSURED 1

	Last name	First name	Date of birth (YYYY/MM/DD)	Relationship to policyholder	Check one: Revocable	Check one: Irrevocable	Share % Total 100%	
Beneficiary(ies)					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry
					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry
					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry
					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry
Contingent					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry

INSURED 2

	Last name	First name	Date of birth (YYYY/MM/DD)	Relationship to policyholder	Check one: Revocable	Check one: Irrevocable	Share % Total 100%	
Beneficiary(ies)					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry
					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry
					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry
					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry
Contingent					☐	☐		☐ Reimb. on death ☐ Reimb. on surrender/expiry

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8. INSURANCE HISTORY

8.1 Other insurance in force or pending

INSURED 1

☐ None

OR

Type of insurance	Insured amount	Accidental death	Name of company	Year of issue (check if pending) P	Personal / business P	Personal / business B	Will the insurance applied for replace the existing insurance contract? Yes	Will the insurance applied for replace the existing insurance contract? No
	$	$		☐	☐	☐	☐	☐
	$	$		☐	☐	☐	☐	☐
	$	$		☐	☐	☐	☐	☐

Complete the prior notice of replacement if required.

INSURED 2

☐ None

OR

Type of insurance	Insured amount	Accidental death	Name of company	Year of issue (check if pending) P	Personal / business P	Personal / business B	Will the insurance applied for replace the existing insurance contract? Yes	Will the insurance applied for replace the existing insurance contract? No
	$	$		☐	☐	☐	☐	☐
	$	$		☐	☐	☐	☐	☐
	$	$		☐	☐	☐	☐	☐

Complete the prior notice of replacement if required.

8.2 Previous insurance coverage

INSURED 1

Have you ever had a life, critical illness or disability insurance application declined, deferred, modified or rated with a higher premium? ☐ Yes ☐ No

If yes:

Month	Year	Name of company	Decision	Reason

INSURED 2

Have you ever had a life, critical illness or disability insurance application declined, deferred, modified or rated with a higher premium? ☐ Yes ☐ No

If yes:

Month	Year	Name of company	Decision	Reason

9. TOBACCO USE

INSURED 1

During the last 12 months, have you smoked cigarettes, cigarillos, cigars or a pipe, or used any form of tobacco or marijuana, or used a substitute such as a nicotine patch or gum?
☐ Yes ☐ No

If yes:

Type	Quantity	Frequency

If you quit smoking in the last 12 months, indicate the date (YYYY/MM) _____

INSURED 2

During the last 12 months, have you smoked cigarettes, cigarillos, cigars or a pipe, or used any form of tobacco or marijuana, or used a substitute such as a nicotine patch or gum?
☐ Yes ☐ No

If yes:

Type	Quantity	Frequency

If you quit smoking in the last 12 months, indicate the date (YYYY/MM) _____

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10. PAYMENT METHOD OF PREMIUM

☐ **Annual invoice** ☐ Cheque enclosed $_____ ☐ Payable on delivery

☐ **Preauthorized payment** Complete section 11. Do not enclose a cheque to cover the initial premium for this method of payment.

11. PREAUTHORIZED DEBIT (PAD) AGREEMENT

I, the undersigned, authorize La Capitale Insurance and Financial Services Inc. (La Capitale) or its agent to debit the fixed monthly amounts required for payments due to La Capitale Insurance and Financial Services Inc. from the account indicated on the enclosed cheque specimen or from the account identified below.

Bank account information

Enclose a cheque specimen or complete: ☐☐☐☐☐ (transit) ☐☐☐ (bank) ☐☐☐☐☐☐☐☐☐☐☐☐ (account no.)

Type of PAD: ☐ Personal ☐ Business

☐ Date of withdrawal determined by insurer at time of issue or the _____ of each month (specify).

You will receive a notice at least 10 days prior to the scheduled date of the first PAD confirming the amount and date of the PADs. This agreement may be cancelled upon receipt by La Capitale of 30 days' written notice prior to the scheduled date of the next PAD. Furthermore, you have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this agreement. To obtain a PAD cancellation form, or for more information about your right to cancel this agreement or your other rights to recourse, contact La Capitale or visit www.cdnpay.ca.

Payor's name

Payor's address (if other than policyholder or insured)

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

SIGNATURE OF PERSON PAYING PREMIUM

X _____

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

12. DECLARATIONS AND APPLICATION SIGNATURES

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

Subject to the general conditions of the contract and the conditions of the Conditional Certificate of Temporary Insurance, if issued, we 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.

We acknowledge that any suicide of a proposed insured during the first two years following the effective date of any life insurance benefit issued for that person shall cause the contract to be null and void with regard to that person and that the Insurer's only obligation shall be limited to the reimbursement of the premiums paid for this benefit.

The policyholder or policyholders acknowledge that they have read the illustration containing information about the product applied for, including guaranteed and non-guaranteed elements and any applicable restrictions, reductions and exclusions. The policyholder or policyholders acknowledge that their financial security advisor has provided them with satisfactory information.

The policyholder or policyholders acknowledge having read and understood the Conditional Certificate of Temporary Insurance, if issued.

We 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 Personal Information Protection Notice.

Moreover, each and every proposed insured consents to the policyholder or policyholders taking out this insurance.

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

* If the policyholder is a company, the application must be signed by the authorized signatories.

POLICYHOLDER'S OR POLICYHOLDERS' SIGNATURE*

X _____ Policyholder's signature

X _____ Policyholder's signature

INSURED 1'S SIGNATURE

X _____ Proposed insured's or legal guardian's signature, if a minor

INSURED 2'S SIGNATURE OR ☐ WP

X _____ Proposed insured's or legal guardian's signature, if a minor

ADVISOR'S SIGNATURE

X _____ Advisor's signature

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13. QUESTIONS FOR THE CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE
(Life Insurance, Disabilty Income or Critical Illness)

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

	INSURED 1		INSURED 2	
	Yes	No	Yes	No
1. Have you ever consulted for, been treated for or shown signs or symptoms of the following: 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?	☐	☐	☐	☐
2. During 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?	☐	☐	☐	☐
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 or rated with a higher premium?	☐	☐	☐	☐
4. Have you ever been or are you currently on leave from work due to disability?	☐	☐	☐	☐

Signature

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

Date (YYYY/MM/DD)

INSURED 1'S SIGNATURE
X
Proposed insured's or legal guardian's signature, if a minor

INSURED 2'S SIGNATURE
X
Proposed insured's or legal guardian's signature, if a minor

ADVISOR'S SIGNATURE
X
Advisor's signature

14. CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE (Life Insurance, Disability Income or Critical Illness)

Give to each policyholder only if the proposed insured or one of the proposed insureds has answered NO to the questions in section 13.

The Conditional Certificate of Temporary Insurance (the "Certificate") guarantees limited insurance coverage while the above-mentioned insurance application 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, declaration or form required prior to reviewing the application.

Termination of Certificate

The temporary coverage provided under this Certificate shall be terminated on the earliest of the following events:

- the effective date of the requested contract;
- the date a counteroffer is sent by the Insurer to the advisor;
- the date a notice is sent by the Insurer to the policyholder declining the requested contract;
- the date a notice is sent by the Insurer to the advisor or to the policyholder regarding its decision to terminate this Certificate;
- the date on which the policyholder requests cancellation of the application; or
- the 60th day following the effective date of the Certificate.

14.1 – 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 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 14.1 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.

14.2 – 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 his or her 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 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

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14. CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE (cont.)

14.3 – 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 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 14.3 applies are those that include a critical illness benefit.

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

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

No advisor may amend the terms of this Certificate.

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

Name: _____

Name: _____

* In the event of a claim, the Insurer shall validate the eligibility of proposed Insured(s).

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

ADVISOR'S SIGNATURE

X _____

Advisor's signature

15. NOTICE

To be given to each policyholder

15.1 – MIB, Inc. Notice

Certain information must be collected when an insurer receives an application for insurance, and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

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

Any information regarding your insurability will be treated as confidential. However, the Insurer and its reinsurers may forward a summary of such information to MIB, a not-for-profit organization formed by life insurance companies. This organization enables information to be exchanged among member companies.

If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB will, upon request, supply such company with information in its files.

The Insurer, or its reinsurers, may also disclose the information held in its files to other life insurance companies to which you may submit an application for life or health insurance, or to which a claim may be submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the US Fair Credit Reporting Act. MIB's address is:

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

MIB receives personal information, and the collection, use and communication of such information are governed by the *Personal Information Protection and Electronic Documents Act* and other provincial legislation. Consequently, MIB safeguards personal information in a manner consistent with standard corporate privacy practices and in accordance with applicable legislation, and information may only be disclosed in accordance with the provisions of the legislation. If you have any questions about how MIB safeguards and protects the confidentiality of your personal information, you can contact MIB's privacy department at privacy@mib.com

15.2 – 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.

15.3 – Personal Information Protection Notice

La Capitale protects the confidentiality of your personal information, which it keeps in a folder named "*Insurance, Annuities, Credit and Associated Financial Services.*" Only employees, mandataries, distribution partners (such as agents and their firms) and service providers have access to your personal information when such access is required to perform their duties, carry out their mandate or fulfill their service contract. In some cases, La Capitale may do business with service providers located outside of Canada. In this situation, some of your personal information may be transferred to another country where it is subject to the legislation in force in that country. All service providers, whether they are located in Canada or not, are required to protect your personal information in accordance with the policies and practices of La Capitale.

You have the right to access your file. You may also have any information corrected if you demonstrate that it is inaccurate or incomplete. Make your request in writing to the following address:

La Capitale Insurance and Financial Services Inc.
Individual Life and Health Insurance Department
625 Saint-Amable St, PO Box 16040
Quebec QC G1K 7X8

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La Capitale
Insurance and
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SECTION A
Medical and non medical information

INSURED 1

First name

Last name

Date of birth (YYYY/MM/DD)

INSURED 2 OR ☐ WP

First name

Last name

Date of birth (YYYY/MM/DD)

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A1. MEDICAL INFORMATION

NOT REQUIRED IF PARAMEDICAL >>>>>>>>>> GO DIRECTLY TO SECTION A2

Medical history

Check YES or NO. Circle each relevant illness, condition or situation. Provide details for each YES answer in the "Explanations" section below or complete the relevant additional questionnaire.

	INSURED 1		INSURED 2 OR ☐ WP	
	Yes	No	Yes	No
1. Have you ever consulted for, been treated for or showed signs or symptoms of the following conditions:				
a) Heart attack, high blood pressure, chest pain, high level of cholesterol, cerebrovascular accident (stroke), aneurysm or any heart or blood vessel disorder?	☐	☐	☐	☐
b) Cancer, tumor, leukemia, lymph node disorder, cyst, polyp, skin disorder, breast disorder, including lumps, unusual discharge or other physical changes?	☐	☐	☐	☐
c) Diabetes, disorder of the thyroid gland or other endocrine disorder?	☐	☐	☐	☐
d) Epilepsy, paralysis, multiple sclerosis, coma, Alzheimer's disease, Parkinson's disease, dizziness, loss of balance, optic neurosis, blurred vision, numbness, tingling or any other neurological disorder, depression, burnout, adjustment disorder, anxiety, fatigue/ overstress or any other psychological, psychiatric or mental disorder? If yes, complete additional questionnaire B1, "Psychological Disorders" on page 24.	☐	☐	☐	☐
e) Hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or other disorder of the liver, stomach or intestines?	☐	☐	☐	☐
f) Asthma, emphysema, chronic bronchitis or any other pulmonary or respiratory disorder? If yes, complete additional questionnaire B2, "Respiratory Disorders" on page 25.	☐	☐	☐	☐
g) Disorder of the bladder, prostate, genitals or reproductive system, kidneys or urine abnormalities?	☐	☐	☐	☐
h) Immune system disorder, AIDS or positive test results for HIV (human immunodeficiency virus)?	☐	☐	☐	☐
i) Arthritis, pain in the vertebral column or other bone or joint disorder?	☐	☐	☐	☐
j) Anemia or other blood disorder, eye or ear disorder or any other disorder not mentioned above?	☐	☐	☐	☐
k) Do you have any symptoms or signs for which you have not yet consulted?	☐	☐	☐	☐
2. Have you ever received treatment or have you been advised to undergo treatment or to consult a physician regarding your consumption of drugs or alcohol?	☐	☐	☐	☐
3. Within the last 5 years, have you undergone medical tests, X-rays, blood tests, follow-up, screening or other diagnostic tests?	☐	☐	☐	☐
4. Do you have to consult a physician or undergo a treatment, surgery or tests which have not yet been performed?	☐	☐	☐	☐
5. Within the last 5 years, have you been disabled or absent from work for a consecutive period of 4 weeks due to illness or injury?	☐	☐	☐	☐
6. Are you taking any medication? (If yes, specify)	☐	☐	☐	☐
7. Have you ever consulted a physician for, received a diagnosis or showed symptoms of abnormal findings after a mammography or biopsy?	☐	☐	☐	☐
8. Within the last 2 years, have you undergone a mammography or breast ultrasound?	☐	☐	☐	☐

Explanations

To be completed for each of the YES answers in the previous section. If you need extra space, attach an extra sheet to this application and ensure it is signed and dated by the proposed insured or legal guardian if a minor.

Question No.	Name of person concerned	Dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted and/or hospitals visited

A1. MEDICAL INFORMATION (cont.)

Height and weight

INSURED 1		INSURED 2 OR ☐ WP	
Height: ☐ cm ☐ ft./in.	Weight: ☐ kg ☐ lb.	Height: ☐ cm ☐ ft./in.	Weight: ☐ kg ☐ lb.
Have you lost 4.5 kg (10 lb.) or more in the last year? ☐ Yes ☐ No	**If yes**, number of kg (lb.) lost: ☐ kg ☐ lb.	Have you lost 4.5 kg (10 lb.) or more in the last year? ☐ Yes ☐ No	**If yes**, number of kg (lb.) lost: ☐ kg ☐ lb.
Reason		Reason	

Personal physician

INSURED 1		INSURED 2 OR ☐ WP	
Name of physician		Name of physician	
Address		Address	
	Area code Tel.		Area code Tel.
Last physician consulted, if different	Date of last consultation (YYYY/MM/DD)	Last physician consulted, if different	Date of last consultation (YYYY/MM/DD)
Reason		Reason	
Results (consultations or treatments recommended)		Results (consultations or treatments recommended)	

Family history

	INSURED 1		INSURED 2 OR ☐ WP	
	Yes	No	Yes	No
Have any of your immediate family members (father, mother, brothers, sisters) ever suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease?	☐	☐	☐	☐

If yes:

INSURED 1

	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death
Father					
Mother					
Brother(s)					
Sister(s)					

If yes:

INSURED 2 OR ☐ WP

	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death
Father					
Mother					
Brother(s)					
Sister(s)					

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A2. NON MEDICAL INFORMATION > MUST ALWAYS BE COMPLETED EVEN WHEN PARAMEDICAL TESTS ORDERED <

If any of the questions are answered "Yes" (except questions 1 and 5), complete the appropriate section of additional questionnaire B3, "Personal Information", starting on page 26.

		INSURED 1		INSURED 2 OR ☐ WP	
		Yes	No	Yes	No
Alcohol	1. Do you drink alcohol?	☐	☐	☐	☐
	If yes, current weekly consumption (number of glasses of beer, wine and/or spirits). _____ _____ _____				
	2. Has your consumption of alcohol changed in the last 5 years?	☐	☐	☐	☐
Aviation (flights)	3. 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?	☐	☐	☐	☐
Bankruptcy	4. Have you declared bankruptcy in the past 5 years? **If so,** indicate the date you were discharged from bankruptcy: _____	☐	☐	☐	☐
Criminal record	5. Have you ever been charged with or found guilty of any criminal offence?	☐	☐	☐	☐
	If yes, specify the type, date, sentence and probation for each offence. _____ _____ _____ _____				
Driving record	Within the last 5 years:				
	6. Has your driver's licence been suspended or revoked?	☐	☐	☐	☐
	7. Have you been found guilty of 3 or more violations of the Highway Safety Code?	☐	☐	☐	☐
Drug use	8. Do you take, or have you ever taken, drugs?	☐	☐	☐	☐
Hazardous sports	9. Do you plan to take part in or, in the last 2 years, have you taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity?	☐	☐	☐	☐
Travel	10. In the last 2 years, have you travelled or resided outside Canada or the United States or do you plan to travel or reside outside of Canada or the United States in the next 2 years?	☐	☐	☐	☐

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A3. ADVISOR'S REPORT

Is this a pre-screening exercise? 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, application for individual or group life insurance declined, deferred or rated with a higher premium in the last 3 years?
☐ No ☐ Yes – **Do not order any requirements**

Reason for application: Details

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

☐ Conversion of individual insurance — If this is a partial conversion with excess amount to be cancelled, complete and attach the cancellation-surrender form available in the illustration software.
☐ with excess amount ☐ without excess amount _____

☐ Conversion of group insurance
☐ with excess amount ☐ without excess amount _____

☐ Guaranteed Insurability Option
☐ with excess amount ☐ without excess amount _____

Have you drawn up and given the Conditional Certificate of Temporary Insurance to the policyholder? ☐ Yes ☐ No

Underwriting requirements

INSURED 1

☐ Ordered on _____ (YYYY/MM/DD)

Medical company:
☐ Portamedic/Hooper Holmes ☐ MedAxio ☐ ExamOne ☐ QUS ☐ Watermark

☐ Paramedical ☐ HIV urine ☐ Prostate specific antigen ☐ Exercise ECG ☐ Inspection report (Portamedic)
☐ Medical examination ☐ Blood profile ☐ Electrocardiogram ☐ Pulmonary X-ray

Confirmation No. _____

INSURED 2

☐ Ordered on _____ (YYYY/MM/DD)

Medical company:
☐ Portamedic/Hooper Holmes ☐ MedAxio ☐ ExamOne ☐ QUS ☐ Watermark

☐ Paramedical ☐ HIV urine ☐ Prostate specific antigen ☐ Exercise ECG ☐ Inspection report (Portamedic)
☐ Medical examination ☐ Blood profile ☐ Electrocardiogram ☐ Pulmonary X-ray

Confirmation No. _____

Service advisor

Name of advisor	Advisor code	General agent	General agent code

Commissions

Name of advisor	Advisor code	Split %	General agent	General agent code
☐ I don't have an advisor code. This is my first application.				
☐ I don't have an advisor code. This is my first application.				
☐ I don't have an advisor code. This is my first application.				

Specific instructions _____

A4. ADVISOR'S DECLARATION

I hereby confirm that I have disclosed the names of the companies that I represent, the fact that I am compensated by commission on the sale of insurance products and that I may receive additional compensation in the form of bonuses, convention participation or other incentives, as well disclosing as any potential conflicts of interest with regard to this sale.

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

A5. AUTHORIZATION

Authorization

We, each and every proposed insured, hereby authorize the Insurer and its reinsurers, for the strict purposes of determining insurability, file management and claims settlement:

a) to gather only that information necessary for the purposes of our file from any individual or organization or public or parapublic institution holding personal information about us, notably from health professionals and medical establishments, the MIB, Inc., financial institutions, insurance and reinsurance companies, personal information agents, investigation agencies, employers or previous employers;

b) to disclose to such individuals and organizations, such as MIB, Inc., only that personal information it has relating to us that is relevant to our file;

c) to make a brief report to MIB, Inc. providing personal information about our health;

d) to request an investigation report relating to us.

In case of death, we expressly authorize the policyholder or policyholders, beneficiary or beneficiaries, our heirs or the liquidator of our estate, to provide the Insurer or its assigns, when required, with any information or authorizations needed to process our file.

This authorization shall also be valid for the collection, use and communication of personal information regarding our minor children insofar as they are concerned by our application. A photocopy of this authorization shall be considered as valid as the original.

Signatures

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

Minors: All insureds age 14 and over in Quebec, and age 16 and over in all other provinces, must sign.

INSURED 1'S SIGNATURE

X _____

Signature of proposed insured or legal guardian if a minor

INSURED 2'S SIGNATURE OR ☐ WP

X _____

Signature of proposed insured or legal guardian if a minor

ADVISOR'S SIGNATURE

X _____

Advisor's signature

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La Capitale
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SECTION B
Additional Questionnaires

If required

INSURED 1
First name
Last name
Date of birth (YYYY/MM/DD)

INSURED 2 OR ☐ WP
First name
Last name
Date of birth (YYYY/MM/DD)

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B1. PSYCHOLOGICAL DISORDERS – Additional Questionnaire

Must be completed if answer to Question 1.d) in Section A1 regarding medical history is "Yes".

INSURED 1

Nature of disorder:

☐ Depression ☐ Adjustment disorder ☐ Anxiety
☐ Burnout ☐ Fatigue/overstress
☐ Other, explain: _____

Date of first episode | Date of last episode | No. of episodes

Hospitalization?
☐ Yes ☐ No

If yes, date (YYYY/MM) | **and** duration of hospitalization

Prescribed drugs?
☐ Yes ☐ No

If yes, names of drugs prescribed

Are you still taking these drugs?
☐ Yes ☐ No

If not, since when? (YYYY/MM)

If yes, which

Disability or absence from work?
☐ Yes ☐ No

Date (YYYY/MM) | Duration

Full recovery?
☐ Yes ☐ No

If yes, since when?

Name of physician who treated or is currently treating you

Date of last consultation (YYYY/MM)

Provide all relevant additional information:

INSURED 2 OR ☐ WP

Nature of disorder:

☐ Depression ☐ Adjustment disorder ☐ Anxiety
☐ Burnout ☐ Fatigue/overstress
☐ Other, explain: _____

Date of first episode | Date of last episode | No. of episodes

Hospitalization?
☐ Yes ☐ No

If yes, date (YYYY/MM) | **and** duration of hospitalization

Prescribed drugs?
☐ Yes ☐ No

If yes, names of drugs prescribed

Are you still taking these drugs?
☐ Yes ☐ No

If not, since when? (YYYY/MM)

If yes, which

Disability or absence from work?
☐ Yes ☐ No

Date (YYYY/MM) | Duration

Full recovery?
☐ Yes ☐ No

If yes, since when?

Name of physician who treated or is currently treating you

Date of last consultation (YYYY/MM)

Provide all relevant additional information:

Signature

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

Date (YYYY/MM/DD)

INSURED 1'S SIGNATURE
X
Proposed insured's or legal guardian's signature, if a minor

INSURED 2'S SIGNATURE OR ☐ WP
X
Proposed insured's or legal guardian's signature, if a minor

ADVISOR'S SIGNATURE
X
Advisor's signature

La Capitale

B2. RESPIRATORY DISORDERS – Additional Questionnaire

Must be completed if answer to Question 1.f) in Section A1 regarding medical history is "Yes".

INSURED 1

Nature of disorder:

☐ Sleep apnea ☐ Asthma ☐ Bronchitis
☐ Emphysema ☐ Obstructive pulmonary disease
☐ Other, specify: _____

Date of diagnosis (YYYY/MM/DD): _____

Are symptoms: ☐ constant? ☐ episodic?

How long do symptoms usually last? _____

Date of first episode including one or more attacks (YYYY/MM/DD): _____

Date of last episode including one or more attacks (YYYY/MM/DD): _____

Except during an episode or when suffering an attack, are you able to, without shortness of breath:

Walk outside in the wind and cold? ☐ Yes ☐ No

Climb 2 flights of stairs? ☐ Yes ☐ No

Full name and address of all physicians consulted	Date of consultation (YYYY/MM/DD)

How frequently do you take the drugs prescribed?

☐ Every day ☐ When suffering a cold or flu ☐ During episodes or attacks only

If no drugs are taken, specify the reason.

Are you receiving or have you received treatment (CPAP, respiratory therapy, or other)? ☐ Yes ☐ No

If yes, specify frequency of use:

☐ Every day ☐ When suffering a cold or flu ☐ During episodes or attacks only

Have you had to be hospitalized? ☐ Yes ☐ No

If yes, name and address of hospital	Date of hospitalization

Have you undergone tests or examinations related to this or these disorders?

☐ Yes ☐ No

If yes, specify tests or examinations	Date (YYYY/MM/DD)

Has this disorder/have these disorders caused you to be absent from work?

☐ Yes ☐ No

If yes, specify dates of absences (YYYY/MM/DD)	Duration of absences

INSURED 2 OR ☐ WP

Nature of disorder:

☐ Sleep apnea ☐ Asthma ☐ Bronchitis
☐ Emphysema ☐ Obstructive pulmonary disease
☐ Other, specify: _____

Date of diagnosis (YYYY/MM/DD): _____

Are symptoms: ☐ constant? ☐ episodic?

How long do symptoms usually last? _____

Date of first episode including one or more attacks (YYYY/MM/DD): _____

Date of last episode including one or more attacks (YYYY/MM/DD): _____

Except during an episode or when suffering an attack, are you able to, without shortness of breath:

Walk outside in the wind and cold? ☐ Yes ☐ No

Climb 2 flights of stairs? ☐ Yes ☐ No

Full name and address of all physicians consulted	Date of consultation (YYYY/MM/DD)

How frequently do you take the drugs prescribed?

☐ Every day ☐ When suffering a cold or flu ☐ During episodes or attacks only

If no drugs are taken, specify the reason.

Are you receiving or have you received treatment (CPAP, respiratory therapy, or other)? ☐ Yes ☐ No

If yes, specify frequency of use:

☐ Every day ☐ When suffering a cold or flu ☐ During episodes or attacks only

Have you had to be hospitalized? ☐ Yes ☐ No

If yes, name and address of hospital	Date of hospitalization

Have you undergone tests or examinations related to this or these disorders?

☐ Yes ☐ No

If yes, specify tests or examinations	Date (YYYY/MM/DD)

Has this disorder/have these disorders caused you to be absent from work?

☐ Yes ☐ No

If yes, specify dates of absences (YYYY/MM/DD)	Duration of absences

Signature

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

Date (YYYY/MM/DD)	INSURED 1'S SIGNATURE	INSURED 2'S SIGNATURE OR ☐ WP	ADVISOR'S SIGNATURE
	X	X	X
	Proposed insured's or legal guardian's signature, if a minor	Proposed insured's or legal guardian's signature, if a minor	Advisor's signature

La Capitale

Application No.: 11665271

B3. PERSONAL INFORMATION – Additional Questionnaire

		INSURED 1	INSURED 2 OR ☐ WP
Aviation (flights)	1. What type of licence do you hold?	☐ None ☐ Flight instructor ☐ Student pilot ☐ Commercial pilot ☐ Private pilot ☐ Airline transport pilot (ATR) ☐ Instrument flight (IFR)	☐ None ☐ Flight instructor ☐ Student pilot ☐ Commercial pilot ☐ Private pilot ☐ Airline transport pilot (ATR) ☐ Instrument flight (IFR)
	Date of issue (YYYY/MM):		
	2. Record of flying time and estimation of future flying time	**Flying hours**	**Flying hours**
	a) No revenue flights	Accumulated: ____ In the last 12 months: ____ In the last 12-24 months: ____ Expected in the next 12 months: ____	Accumulated: ____ In the last 12 months: ____ In the last 12-24 months: ____ Expected in the next 12 months: ____
	b) Revenue flights As crew member or paid employee on duty during flights	Accumulated: ____ In the last 12 months: ____ In the last 12-24 months: ____ Expected in the next 12 months: ____	Accumulated: ____ In the last 12 months: ____ In the last 12-24 months: ____ Expected in the next 12 months: ____
	c) Military flights As crew member or in another capacity	Accumulated: ____ In the last 12 months: ____ In the last 12-24 months: ____ Expected in the next 12 months: ____	Accumulated: ____ In the last 12 months: ____ In the last 12-24 months: ____ Expected in the next 12 months: ____
	3. Has your licence ever been suspended?	☐ Yes ☐ No	☐ Yes ☐ No
	If yes, date (YYYY/MM):		
	If yes, reason:		
	4. Have you ever been involved in an accident?	☐ Yes ☐ No	☐ Yes ☐ No
	If yes, specify:		
	5. What is the purpose of your flights?	☐ Recreation ☐ Commercial	☐ Recreation ☐ Commercial
	If commercial:	☐ Chemical spraying ☐ Advertising ☐ Search/rescue ☐ Forest fire-fighting ☐ Aerial photography	☐ Chemical spraying ☐ Advertising ☐ Search/rescue ☐ Forest fire-fighting ☐ Aerial photography
	Other, specify:		
	6. Type of aircraft used:	☐ Single-engine ☐ Multiengine ☐ Helicopter ☐ Motorized ultralight ☐ Hot air balloon ☐ Motorized hang glider	☐ Single-engine ☐ Multiengine ☐ Helicopter ☐ Motorized ultralight ☐ Hot air balloon ☐ Motorized hang glider
	Other, specify:		
	Type of construction:	☐ Industrial ☐ Home-built	☐ Industrial ☐ Home-built
	7. Do you expect to make flights different from those made to date?	☐ Yes ☐ No	☐ Yes ☐ No
	If yes, specify:		
	8. Have you definitively ceased flying?	☐ Yes ☐ No	☐ Yes ☐ No

		INSURED 1		INSURED 2 OR ☐ WP	
		Yes	No	Yes	No
Alcohol	1. When and why did you change your alcohol consumption?				
	2. Indicate weekly consumption in the last 5 years (number of glasses of beer, wine and/or spirits):				
	3. Have you ever been advised to reduce your alcohol consumption or been treated for alcohol abuse?	☐	☐	☐	☐
	If yes, specify dates, names and addresses of the physicians and institutions consulted:				
	4. Are you a member of a support group?	☐	☐	☐	☐
	If yes, since when? (YYYY/MM)				
	5. Have you ever been arrested for impaired driving?	☐	☐	☐	☐
	If yes, specify the date(s):				

Signature

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

Date (YYYY/MM/DD)	INSURED 1'S SIGNATURE	INSURED 2'S SIGNATURE OR ☐ WP	ADVISOR'S SIGNATURE
	X Proposed insured's or legal guardian's signature, if a minor	X Proposed insured's or legal guardian's signature, if a minor	X Advisor's signature

B3. PERSONAL INFORMATION – Additional Questionnaire (cont.)

		INSURED 1		INSURED 2 OR ☐ WP	
		Yes	No	Yes	No
Driving record	1. Why was your Driver's Licence suspended or revoked?				
In addition to the Driving Record Questionnaire, also attach the form required by the motor vehicle bureau of your province or territory to authorize disclosure of a driving record that is available in the illustration software.	☐ Driving while impaired ☐ Other criminal driving offence ☐ Unpaid fines ☐ Accumulation of demerit points ☐ Other, specify: _____				
	b) Indicate the suspension or revocation date (YYYY/MM): _____ Duration: _____				
	c) When will you recover your licence or when do you expect to recover it? (YYYY/MM) _____				
	d) Have you driven while under suspension?	☐	☐	☐	☐
	e) Have you been found guilty of 3 or more violations of the Highway Safety Code?	☐	☐	☐	☐
	If yes, specify the nature of each offence, number of fines, date and number of demerit points lost: _____				
Drug use	1. What type of drugs do you use or have you used? Answer "YES" or "NO" for each type of drug:				
	a) Marijuana (cannabis, hashish, pot, etc.)	☐	☐	☐	☐
	b) Cocaine (crack)	☐	☐	☐	☐
	c) Hallucinogens: Ecstasy, DMT, LSD (acid), mescaline, peyote, psilocybine (magic mushrooms)	☐	☐	☐	☐
	d) Opium and derivatives: Codeine, Demerol, heroine, methadone, morphine	☐	☐	☐	☐
	e) Barbiturates: Amytal, Nembutal, Pentobarbital, Phenobarbital, Seconal	☐	☐	☐	☐
	f) Amphetamines: Benzedrine, Dexedrine, Methedrine, pep, speed, ups, wake ups	☐	☐	☐	☐
	g) Other, specify: _____				
	For each drug, specify dosage/quantity, frequency and duration of consumption. _____				
	2. Have you received treatment or taken part in any drug rehabilitation program?	☐	☐	☐	☐
	If yes, specify dates, names and addresses of the physicians and institutions consulted: _____				
	3. If you no longer use drugs, what motivated you to stop taking them? _____				
	4. Do you intend to use drugs in the future?	☐	☐	☐	☐
Travel	1. a) Date of departure (YYYY/MM/DD): _____ Duration of trip: _____				
	b) Country: _____ City: _____				
	c) Reason: _____ Occupation abroad: _____				
	d) Name of employer or organization responsible: _____				
	e) Do you plan to travel outside major urban centres?	☐	☐	☐	☐
	If yes, specify: _____				
	f) Previous stays abroad (places, dates and duration): _____				

Hazardous sports		INSURED 1	INSURED 2 OR ☐ WP
☐ **SKYDIVING**	1. Total number of jumps to date:	_____	_____
	2. Are you a member of a club?	☐ Yes ☐ No	☐ Yes ☐ No
	3. Do you carry out or take part in: Record attempts	☐ Yes ☐ No	☐ Yes ☐ No
	Jumps in a professional capacity	☐ Yes ☐ No	☐ Yes ☐ No
	Competitions, demonstrations, acrobatics or stunts	☐ Yes ☐ No	☐ Yes ☐ No
	Jumps using experimental equipment	☐ Yes ☐ No	☐ Yes ☐ No
	4. Date of last participation (YYYY/MM):	_____	_____
	5. Have you definitively ceased participation in this sport?	☐ Yes ☐ No	☐ Yes ☐ No

Continued on the next page

Signature

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

Date (YYYY/MM/DD)	INSURED 1'S SIGNATURE	INSURED 2'S SIGNATURE OR ☐ WP	ADVISOR'S SIGNATURE
_____	X _____	X _____	X _____
	Proposed insured's or legal guardian's signature, if a minor	Proposed insured's or legal guardian's signature, if a minor	Advisor's signature

La Capitale

Application No.: 11665271

B3. PERSONAL INFORMATION – Additional Questionnaire (cont.)

Hazardous sports (cont.)

			INSURED 1	INSURED 2 OR ☐ WP
☐ **MOUNTAIN CLIMBING**	1. Type of climbing:		☐ Trail climbing ☐ Rock climbing	☐ Trail climbing ☐ Rock climbing
	2. Surface:	Snow	☐ Yes ☐ No	☐ Yes ☐ No
		Glacier	☐ Yes ☐ No	☐ Yes ☐ No
		Ice	☐ Yes ☐ No	☐ Yes ☐ No
		Other, specify:		
	3. Location:	North America	☐ Yes ☐ No	☐ Yes ☐ No
		Europe	☐ Yes ☐ No	☐ Yes ☐ No
		Elsewhere, specify:		
	4. When did you start practising this sport? (YYYY/MM)			
	5. Date of last participation (YYYY/MM):			
	6. Have you definitively ceased participation in this sport?		☐ Yes ☐ No	☐ Yes ☐ No
☐ **RACING**	1. Type of racing: a) Automobile		☐ Drag ☐ Stock car ☐ Sports car ☐ Demolition ☐ Midget ☐ Championship	☐ Drag ☐ Stock car ☐ Sports car ☐ Demolition ☐ Midget ☐ Championship
		Other, specify:		
	b) Motorcycle		☐ Motocross ☐ Drag ☐ Cross-country	☐ Motocross ☐ Drag ☐ Cross-country
		Other, specify:		
	c) Snowmobile		☐ Yes ☐ No	☐ Yes ☐ No
	d) Boat		☐ Yes ☐ No	☐ Yes ☐ No
	2. Modified vehicle:	Modified for safety	☐ Yes ☐ No	☐ Yes ☐ No
		Modified for performance	☐ Yes ☐ No	☐ Yes ☐ No
		If yes: Indicate the make, model and no. of cylinders		
	3. Number of races:		Last 12 months:	Last 12 months:
			Next 12 months:	Next 12 months:
	4. Speeds reached (km/h or mph):		Maximum speed:	Maximum speed:
			Average speed:	Average speed:
	5. Location of races:			
	6. When did you start practising this sport? (YYYY/MM)			
	7. Capacity in which you practise this sport:		☐ Amateur ☐ Professional	☐ Amateur ☐ Professional
	8. Do you make record attempts?		☐ Yes ☐ No	☐ Yes ☐ No
	9. Have you definitively ceased participation in this sport?		☐ Yes ☐ No	☐ Yes ☐ No
☐ **SCUBA DIVING**	1. Specify the purpose of your dives:	Recreation	☐ Yes ☐ No	☐ Yes ☐ No
		Commercial	☐ Yes ☐ No	☐ Yes ☐ No
		If commercial, specify:		
	2. Certification obtained:		☐ None ☐ *Scuba Diver* (Basic) ☐ *Open Water Diver* ☐ *Advanced Open Water Diver* ☐ *Master Diver*/Instructor	☐ None ☐ *Scuba Diver* (Basic) ☐ *Open Water Diver* ☐ *Advanced Open Water Diver* ☐ *Master Diver*/Instructor
	3. a) Specify the number of dives and total hours spent at depths of 0-75 feet, 76-100 feet and over 100 feet in the last 24 months.			
	b) Specify the number of dives and total hours you expect to spend at depths of 0-75 feet, 76-100 feet and over 100 feet in the next 12 months.			
	4. Do you practise specialized dives:	Under ice	☐ Yes ☐ No	☐ Yes ☐ No
		Inside caves	☐ Yes ☐ No	☐ Yes ☐ No
		Exploring wrecks	☐ Yes ☐ No	☐ Yes ☐ No
		Search/rescue	☐ Yes ☐ No	☐ Yes ☐ No
	5. Do you always dive accompanied by a certified diver?		☐ Yes ☐ No	☐ Yes ☐ No
	6. Have you definitively ceased participation in this sport?		☐ Yes ☐ No	☐ Yes ☐ No
☐ **OTHER HAZARDOUS SPORT**	1. Specify the sport practised:			
	2. Are you a member of a club?		☐ Yes ☐ No	☐ Yes ☐ No
		If yes, since when? (YYYY/MM)		
	3. Capacity in which you practise this sport:		☐ Amateur ☐ Professional	☐ Amateur ☐ Professional
	4. Do you make record attempts?		☐ Yes ☐ No	☐ Yes ☐ No
	5. Date of last participation (YYYY/MM):			
	6. Have you definitively ceased participation in this sport?		☐ Yes ☐ No	☐ Yes ☐ No

Signature

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

Date (YYYY/MM/DD)	INSURED 1'S SIGNATURE	INSURED 2'S SIGNATURE OR ☐ WP	ADVISOR'S SIGNATURE
	X Proposed insured's or legal guardian's signature, if a minor	X Proposed insured's or legal guardian's signature, if a minor	X Advisor's signature

La Capitale

B4. CHILDREN'S CRITICAL ILLNESS – Additional Questionnaire

Children's Critical Illness

	INSURED 1		INSURED 2	
	Yes	No	Yes	No
1. Has this child ever consulted a physician for, been diagnosed with or showed any signs or symptoms of any of the following conditions:				
a) Cardiac malformation or other congenital abnormality?	☐	☐	☐	☐
b) Attention deficit disorder, autism, cerebral palsy, amyotrophic lateral sclerosis, muscular dystrophy, cystic fibrosis or delay in physical or mental development?	☐	☐	☐	☐
2. Is the child under 1 year old?	☐	☐	☐	☐
If yes, was he or she born more than 4 weeks prematurely?	☐	☐	☐	☐

INSURED 1

3. Has any grandparent suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease? ☐ Yes ☐ No

If yes:

Family member	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death
Grandmother (maternal)					
Grandfather (maternal)					
Grandmother (paternal)					
Grandfather (paternal)					

4. Does the child have any brothers or sisters? ☐ Yes ☐ No **If yes,** how many? _____

5. List below any life, critical illness or disability insurance in force or pending on the lives of parents, brothers and sisters:

Family member	Insured amount – critical illness	Insured amount – life insurance	Insured amount – disability	Name of company	Year of issue
Father					
Mother					
Brother(s)					
Sister(s)					

6. Is the insured amount applied for greater than $100,000? ☐ Yes ☐ No **If yes,** Parents' annual income: $ _____ Parents' net worth (assets-liabilities): $ _____

INSURED 2

3. Has any grandparent suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease? ☐ Yes ☐ No

If yes:

Family member	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death
Grandmother (maternal)					
Grandfather (maternal)					
Grandmother (paternal)					
Grandfather (paternal)					

4. Does the child have any brothers or sisters? ☐ Yes ☐ No **If yes,** how many? _____

5. List below any life, critical illness or disability insurance in force or pending on the lives of parents, brothers and sisters:

Family member	Insured amount – critical illness	Insured amount – life insurance	Insured amount – disability	Name of company	Year of issue
Father					
Mother					
Brother(s)					
Sister(s)					

6. Is the insured amount applied for greater than $100,000? ☐ Yes ☐ No **If yes,** Parents' annual income: $ _____ Parents' net worth (assets-liabilities): $ _____

Signature

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

Date (YYYY/MM/DD)	INSURED 1'S SIGNATURE	INSURED 2'S SIGNATURE	ADVISOR'S SIGNATURE
	X	X	X
	Proposed insured's or legal guardian's signature, if a minor	Proposed insured's or legal guardian's signature, if a minor	Advisor's signature

La Capitale

Application No.: 11665271

B5. DISABILITY INCOME BENEFIT – Additional Questionnaire

If the purpose of the application is to cover a loan, attach proof of loan indicating the names of the borrowers, the date and balance of the loan and the monthly payment amount.

If the purpose of the application is to cover a lease, attach a copy of the lease.

If the Disability Income Benefit applied for is > $2,000 for income replacement, attach proof of income:

Employee: Copy of pay stub.

Self-employed: Copy of last 2 annual notices of assessment from the Canada Revenue Agency.

INSURED 1

PURPOSE OF APPLICATION

☐ **To cover a loan**

☐ Mortgage loan or line of credit ☐ Personal loan ☐ Commercial loan ☐ Agricultural 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**

☐ **Income replacement**

INSURED 2

PURPOSE OF APPLICATION

☐ **To cover a loan**

☐ Mortgage loan or line of credit ☐ Personal loan ☐ Commercial loan ☐ Agricultural 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**

☐ **Income replacement**

Answer all questions regardless of the purpose of the application.

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

Name and address of your employer or company

Type of company (line of business)

Number of years with this employer or self-employed

Number of hours worked/week

Number of weeks worked/year

Number of years in a similar company

Type of employment: Temporary ☐ Permanent ☐

What is your job title?

Brief description of your job duties

Do you have any disability insurance, in force or pending, through your employer? ☐ Yes ☐ No

If yes:

Name of insurance company | % of salary

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

If yes:

Year of issue	Name of insurance company	Monthly benefit
		$ /month
		$ /month

Additional comments

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

Name and address of your employer or company

Type of company (line of business)

Number of years with this employer or self-employed

Number of hours worked/week

Number of weeks worked/year

Number of years in a similar company

Type of employment: Temporary ☐ Permanent ☐

What is your job title?

Brief description of your job duties

Do you have any disability insurance, in force or pending, through your employer? ☐ Yes ☐ No

If yes:

Name of insurance company | % of salary

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

If yes:

Year of issue	Name of insurance company	Monthly benefit
		$ /month
		$ /month

Additional comments

Signature

Date (YYYY/MM/DD)

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

INSURED 1'S SIGNATURE	INSURED 2'S SIGNATURE	ADVISOR'S SIGNATURE
X	X	X
Proposed insured's or legal guardian's signature, if a minor	Proposed insured's or legal guardian's signature, if a minor	Advisor's signature

La Capitale

B6. CHILDREN'S LIFE INSURANCE RIDER – Additional Questionnaire

Must be completed if Children's Life Insurance Rider is applied for. If there are more than 2 children, use as many extra questionnaires as necessary.

Insured amount $ _____ **The insured amount must be the same for all children.**

Children
The children must be the insured's to whose coverage the rider is attached, as indicated on the child's birth certificate or by virtue of legal adoption.

Child	Last name	First name	Height	Weight	Gender	Date of birth (YYYY/MM/DD)
1					☐ M ☐ F	
2					☐ M ☐ F	

Beneficiary designation

Last name _____ First name _____ Relationship to the policyholder _____

☐ Revocable ☐ Irrevocable

Other insurance in force or pending

CHILD 1

☐ None **OR**

Type of insurance	Insured amount	Name of company	Year of issue (check if pending)	P
	$			☐
	$			☐

CHILD 2

☐ None **OR**

Type of insurance	Insured amount	Name of company	Year of issue (check if pending)	P
	$			☐
	$			☐

Medical and non medical history
Check YES or NO. Circle each relevant illness, condition or situation. Provide details for each YES answer in the "Explanations" section below.

	CHILD 1		CHILD 2	
	Yes	No	Yes	No
1. Has the child ever had an application for life insurance declined, deferred or approved with a higher premium?	☐	☐	☐	☐
2. Has the child ever consulted for, been treated for or hospitalized for any of the following:				
a) Cardiac or cerebral malformation, diabetes, cancer, tumor, leukemia or kidney disorder?	☐	☐	☐	☐
b) Asthma, convulsions or seizure, epilepsy, neurological disorder, depression or anxiety, Acquired Immunodeficiency Syndrome (AIDS), AIDS-related syndrome or positive test results for HIV?	☐	☐	☐	☐
c) Liver disorder, Hepatitis B or C or Hepatitis B or C carrier?	☐	☐	☐	☐
d) Alcohol or drug abuse?	☐	☐	☐	☐
3. Within the last 2 years, has the child:				
a) Flown a plane or taken flying or skydiving lessons, practised scuba diving, hang gliding or any other hazardous sports, or does the child intend to do any of the above?	☐	☐	☐	☐
b) Had his or her driver's licence restricted or revoked, or does the child have 3 or more violations of the Highway Safety Code?	☐	☐	☐	☐

Explanations
To be completed for each of the YES answers in the previous section. If you need extra space, attach an extra sheet to this application and ensure it is signed and dated by the proposed insured or legal guardian if a minor.

Question No.	Name of person concerned	Dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted and/or hospitals visited

Signature
Date (YYYY/MM/DD) _____

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

INSURED 1'S SIGNATURE X _____
Proposed insured's or legal guardian's signature, if a minor

INSURED 2'S SIGNATURE X _____
Proposed insured's or legal guardian's signature, if a minor

ADVISOR'S SIGNATURE X _____
Advisor's signature

La Capitale

Application No.: 11665271

B7. CHILDREN'S CRITICAL ILLNESS RIDER – Additional Questionnaire

Must be completed if Children's Critical Illness Rider is applied for. If there are more than 2 children, use as many extra questionnaires as necessary.

Insured amount $ _____ **The insured amount must be the same for all children.**

Children

The children must be the insured's to whose coverage the rider is attached, as indicated on the child's birth certificate or by virtue of legal adoption.

Child	Last name	First name	Height	Weight	Gender	Date of birth (YYYY/MM/DD)
1					☐ M ☐ F	
2					☐ M ☐ F	

Other insurance in force or pending

CHILD 1

☐ None **OR**

Type of insurance	Insured amount	Name of company	Year of issue (check if pending)	P
	$			☐
	$			☐

CHILD 2

☐ None **OR**

Type of insurance	Insured amount	Name of company	Year of issue (check if pending)	P
	$			☐
	$			☐

PERSONAL INFORMATION

CHILD 1

1. Does the child have any brothers or sisters? ☐ Yes ☐ No **If yes,** how many? _____

2. List below any life, critical illness or disability insurance in force or pending on the lives of parents, brothers and sisters:

Family member	Insured amount – critical illness	Insured amount – life insurance	Insured amount – disability	Name of company	Year of issue
Father					
Mother					
Brother(s)					
Sister(s)					

3. Is the insured amount applied for greater than $100,000? ☐ Yes ☐ No **If yes,** Parents' annual income: $ _____ Parents' net worth (assets-liabilities): $ _____

CHILD 2

1. Does the child have any brothers or sisters? ☐ Yes ☐ No **If yes,** how many? _____

2. List below any life, critical illness or disability insurance in force or pending on the lives of parents, brothers and sisters:

Family member	Insured amount – critical illness	Insured amount – life insurance	Insured amount – disability	Name of company	Year of issue
Father					
Mother					
Brother(s)					
Sister(s)					

3. Is the insured amount applied for greater than $100,000? ☐ Yes ☐ No **If yes,** Parents' annual income: $ _____ Parents' net worth (assets-liabilities): $ _____

Tobacco use

CHILD 1

During the last 12 months, has the child smoked cigarettes, cigarillos, cigars or a pipe, or used any form of tobacco or marijuana, or used a substitute such as a nicotine patch or gum? ☐ Yes ☐ No

If yes:

Type	Quantity	Frequency

If the child quit smoking in the last 12 months, indicate the date (YYYY/MM) _____

CHILD 2

During the last 12 months, has the child smoked cigarettes, cigarillos, cigars or a pipe, or used any form of tobacco or marijuana, or used a substitute such as a nicotine patch or gum? ☐ Yes ☐ No

If yes:

Type	Quantity	Frequency

If the child quit smoking in the last 12 months, indicate the date (YYYY/MM) _____

Continued on the next page

B7. CHILDREN'S CRITICAL ILLNESS RIDER – Additional Questionnaire (cont.)

MEDICAL INFORMATION

Family history

Have any immediate family members (father, mother, brothers, sisters) ever suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease?

CHILD 1		CHILD 2	
Yes	No	Yes	No
☐	☐	☐	☐

If yes:

CHILD 1

Family member	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death
Father					
Mother					
Brother(s)					
Sister(s)					

If yes:

CHILD 2

Family member	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death
Father					
Mother					
Brother(s)					
Sister(s)					

Has any grandparent suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis or any other hereditary disease?

CHILD 1		CHILD 2	
Yes	No	Yes	No
☐	☐	☐	☐

If yes:

CHILD 1

Family member	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death
Grandmother (maternal)					
Grandfather (maternal)					
Grandmother (paternal)					
Grandfather (paternal)					

If yes:

CHILD 2

Family member	Name of disease (if cancer, specify type)	Age at diagnosis of the disease	Age if alive	Age at death	Cause of death
Grandmother (maternal)					
Grandfather (maternal)					
Grandmother (paternal)					
Grandfather (paternal)					

Continued on the next page

La Capitale

Application No.: 11665271

B7. CHILDREN'S CRITICAL ILLNESS RIDER – Additional Questionnaire (cont.)

MEDICAL INFORMATION (cont.)

	CHILD 1	CHILD 2
Personal physician	Name of physician Address Area code Tel. Last physician consulted, if different Date of last consultation (YYYY/MM/DD) Reason Results (consultations or treatments recommended)	Name of physician Address Area code Tel. Last physician consulted, if different Date of last consultation (YYYY/MM/DD) Reason Results (consultations or treatments recommended)
Height and weight	Height: ☐ cm ☐ ft./in. Weight: ☐ kg ☐ lb Has he or she lost 4.5 kg (10 lb) or more in the last year? ☐ Yes ☐ No **If yes**, number of kg (lb) lost: ☐ kg ☐ lb Reason	Height: ☐ cm ☐ ft./in. Weight: ☐ kg ☐ lb Has he or she lost 4.5 kg (10 lb) or more in the last year? ☐ Yes ☐ No **If yes**, number of kg (lb) lost: ☐ kg ☐ lb Reason

Medical history

Check YES or NO. Circle the relevant illness, condition or situation. Provide details for each YES answer in the "Explanations" section on page 35 or complete the relevant additional questionnaire.

	CHILD 1 Yes	CHILD 1 No	CHILD 2 Yes	CHILD 2 No
1. Has the child ever consulted a physician for, been diagnosed with or showed any signs or symptoms of any of the following conditions:				
a) Cardiac malformation or other congenital abnormality?	☐	☐	☐	☐
b) Attention deficit disorder, autism, cerebral palsy, amyotrophic lateral sclerosis, muscular dystrophy, cystic fibrosis or delay in physical or mental development?	☐	☐	☐	☐
2. Is the child under 1 year old?	☐	☐	☐	☐
If yes, was he or she born more than 4 weeks prematurely?	☐	☐	☐	☐
3. Has the child ever consulted for, been treated for or shown signs or symptoms of the following conditions:				
a) Heart attack, high blood pressure, chest pain, high level of cholesterol, cerebrovascular accident (stroke), aneurysm or any heart or blood vessel disorder?	☐	☐	☐	☐
b) Cancer, tumor, leukemia, lymph node disorder, cyst, polyp, skin disorder, breast disorder, including lumps, unusual discharge or other physical changes?	☐	☐	☐	☐
c) Diabetes, disorder of the thyroid gland or other endocrine disorder?	☐	☐	☐	☐
d) Epilepsy, paralysis, multiple sclerosis, coma, Alzheimer's disease, Parkinson's disease, dizziness, loss of balance, optic neurosis, blurred vision, numbness, tingling or any other neurological disorder, depression, burnout, adjustment disorder, anxiety, fatigue/overstress or any other psychological, psychiatric or mental disorder? If yes, complete the additional questionnaire "Psychological disorders" available in the illustration software.	☐	☐	☐	☐
e) Hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or other disorder of the liver, stomach or intestines?	☐	☐	☐	☐
f) Asthma, emphysema, chronic bronchitis or any other pulmonary or respiratory disorder? If yes, complete the additional questionnaire "Respiratory disorders" available in the illustration software.	☐	☐	☐	☐
g) Disorder of the bladder, prostate, genitals or reproductive system, kidneys or urine abnormalities?	☐	☐	☐	☐
h) Immune system disorder, AIDS or positive test results for HIV (human immunodeficiency virus)?	☐	☐	☐	☐
i) Arthritis, pain in the vertebral column or other bone or joint disorder?	☐	☐	☐	☐
j) Anemia or other blood disorder, eye or ear disorder or any other disorder not mentioned above?	☐	☐	☐	☐
k) Does the child have any symptoms or signs for which he or she has not yet consulted?	☐	☐	☐	☐
4. Within the last 5 years, has the child undergone medical tests, X-rays, blood tests, follow-up, screening or other diagnostic tests?	☐	☐	☐	☐
5. Does the child have to consult a physician, undergo a treatment, surgery or tests which have not yet been performed?	☐	☐	☐	☐
6. Is the child currently taking any medication? (If yes, specify)	☐	☐	☐	☐

Continued on the next page

B7. CHILDREN'S CRITICAL ILLNESS RIDER – Additional Questionnaire (cont.)

Explanations

To be completed for all YES answers in the "Medical history" section. If you need extra space, attach an extra sheet to this application and ensure it is signed and dated by the proposed insured or legal guardian if a minor.

Question No.	Name of person concerned	Dates of consultations, reasons, results, hospitalizations, surgery, names and addresses of physicians consulted and/or hospitals visited

NON MEDICAL INFORMATION – TO BE COMPLETED FOR CHILDREN AGE 15 OR OVER

If any of the questions are answered Yes (except questions 1 and 3), complete the appropriate questionnaire available in the illustration software.

		CHILD 1 Yes	CHILD 1 No	CHILD 2 Yes	CHILD 2 No
Alcohol	1. Does the child drink alcohol?	☐	☐	☐	☐
	If yes, current weekly consumption (number of glasses of beer, wine and/or spirits).				
Aviation (flights)	2. Does the child plan to take part in or, in the last 2 years, has he or she taken part in flights other than as a passenger?	☐	☐	☐	☐
Criminal record	3. Has the child ever been charged with or found guilty of any criminal offence?	☐	☐	☐	☐
	If yes, specify the type, date, sentence and probation for each offence.				
Driving record	Within the last 2 years:				
	4. Has the child's driver's licence been suspended or revoked?	☐	☐	☐	☐
	5. Has the child been found guilty of 3 or more violations of the Highway Safety Code?	☐	☐	☐	☐
Drug use	6 Does the child take, or has the child ever taken drugs?	☐	☐	☐	☐
Hazardous sports	7. Does the child plan to take part in or, in the last 2 years, has he or she taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity?	☐	☐	☐	☐
Travel	8. In the last 2 years, has the child travelled or resided outside Canada or the United States or does the child plan to travel or reside outside of Canada or the United States in the next 2 years?	☐	☐	☐	☐

Signature

We, each and every proposed insured, hereby confirm that the answers given in this questionnaire are true and complete.

Date (YYYY/MM/DD)	INSURED 1'S SIGNATURE	INSURED 2'S SIGNATURE	ADVISOR'S SIGNATURE
	X	X	X
	Proposed insured's or legal guardian's signature, if a minor	Proposed insured's or legal guardian's signature, if a minor	Advisor's signature

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