Safe Driver
Application Form

La Capitale

In this application form, "the Insurer" means La Capitale Financial Security Insurance Company.

Indicate if this is: ◯ a new application form ◯ a reinstatement OR
◯ an additional coverage to existing contract

Contract No. Leave this blank if this is a new application form

1 POLICYHOLDER/INSURED'S INFORMATION

Language of correspondence	Sex	Last name	First name
◯ English ◯ French	◯ Male ◯ Female		

Last name at birth (if different)	Age[1]	Date of birth[1] Year / Month / Day

Address (No, street, apt.)

City	Province	Postal code	Home tel.

◯ Cell tel. ◯ Work tel.	(extension)	Email address

Occupation	Height	Weight
	_____ cm / _____ ft. _____ in.	_____ kg / _____ lbs.

Status
◯ Canadian citizen ◯ Permanent resident ◯ Temporary resident ◯ Other: _____

2 VERIFICATION OF POLICYHOLDER/INSURED'S IDENTITY

ID (Original documents only)	Document No.
◯ Passport ◯ Driver's licence ◯ Health Insurance card (except Ont., Man., P.E.I.) ◯ Other photo ID issued by a federal or provincial government: _____	

Expiry date (if available) Year / Month	Jurisdiction of issue	Province or country of issue

3 ELIGIBILITY

To be eligible for Safe Driver, the policyholder/insured needs to be able to answer *NO* to questions 1, 2, 3 and 4.

1. In the last 3 years, have you been convicted of driving while intoxicated or been charged with careless/dangerous driving?	◯ Yes ◯ No
2. Are you a driver of an ambulance, city bus, taxi or transportation service such as, but not limited to, Uber, Lyft, limo or tow truck as your current occupation? Or are you a paramedic, fire fighter, or a police officer?	◯ Yes ◯ No
3. Are you currently disabled or receiving disability benefits?	◯ Yes ◯ No
4. Do you engage in competition, racing or speed contests?	◯ Yes ◯ No
5. Do you already have Safe Driver coverage or do you have an application pending for such coverage?	◯ Yes ◯ No

Note 1: The policyholder/insured must be age 16 to 80 inclusive.

4 BENEFICIARY INFORMATION (for the Accidental Death benefit)

A beneficiary is not designated: If a beneficiary is not designated, any benefits will be paid to the policyholder/insured's estate.

Revocable and irrevocable beneficiaries: A beneficiary designation is revocable unless otherwise indicated. However, in Quebec if the named beneficiary is the person to whom the policyholder/insured is married or civilly united, this designation is considered irrevocable unless the policyholder/insured indicates that he or she wishes for the designation to be REVOCABLE.

Designating an irrevocable beneficiary can have significant consequences. To replace a beneficiary designated as irrevocable, or carry out certain changes or transactions, the beneficiary's consent must be obtained. A minor irrevocable beneficiary cannot consent to a change or transaction, and the minor irrevocable beneficiary's parents and legal guardian are also unable to sign a document in that regard on his or her behalf.

Minor beneficiary: Outside Quebec, if a minor is the designated beneficiary, it is recommended that a trustee also be named. By naming a trustee, the benefit is payable to the trustee who will hold it in trust for the minor beneficiary until he or she is of legal age (not applicable in Quebec). Any amount payable to a beneficiary who has reached the age of majority is payable directly to this person. In Quebec, the minor beneficiary's legal guardian will receive the payable benefit unless an official trustee has been named.

Estate, successors and legal heirs: The terms "estate", "successors" or "legal heirs" refer to the policyholder/insured's estate, successors or legal heirs.

Last name	First name	Date of birth Month Day Year	Relationship to the policyholder/insured	Check one Revocable	Check one Irrevocable	Share % Total: 100%
				◯	◯	
				◯	◯	

5 PREMIUM RATE TABLE (including policy fees) AND CHOICE OF COVERAGE

SAFE DRIVER						
	Coverages				Premium	
Number of units	Total disability (monthly benefit)	Hospitalization (daily benefit)	Accidental death	Total permanent disability benefits	Annual	Monthly
1	$200	$50	$2,500	$20,000	$72.06	$6.49
2	$400	$100	$5,000	$40,000	$114.12	$10.27
3	$600	$150	$7,500	$60,000	$156.18	$14.06
4	$800	$200	$10,000	$80,000	$198.24	$17.84
5	$1,000	$250	$12,500	$100,000	$240.30	$21.63
6	$1,200	$300	$15,000	$120,000	$282.36	$25.41
7	$1,400	$350	$17,500	$140,000	$324.42	$29.20
8	$1,600	$400	$20,000	$160,000	$366.48	$32.98

CHOICE OF COVERAGE

Coverage	Monthly benefit		Annual premium		OR	Monthly premium	
◯ Safe Driver	$		$			$	
◯ All Accident Rider (Must complete Sections 6 and 7)	$	+	$	+		$	+
			Total annual premium			Total monthly premium	
		=	$		=	$	

ALL ACCIDENT RIDER[2]		
Monthly benefit	Annual premium	Monthly premium
$100	$62.07	$5.59
$200	$104.14	$9.37
$300	$146.21	$13.16
$400	$188.28	$16.95
$500	$230.35	$20.73
$600	$272.42	$24.52
$700	$314.49	$28.30
$800	$356.56	$32.09
$900	$398.63	$35.88
$1,000	$440.70	$39.66
$1,100	$482.77	$43.45
$1,200	$524.84	$47.24
$1,300	$566.91	$51.02
$1,400	$608.98	$54.81
$1,500	$651.05	$58.59
$1,600	$693.12	$62.38
$1,700	$735.19	$66.17
$1,800	$777.26	$69.95
$1,900	$819.33	$73.74
$2,000	$861.40	$77.53

2. If the policyholder/insured is retired, a student or a homemaker, the maximum monthly benefit is $600.

IMPORTANT: SECTIONS 6, 7, AND 8 CONCERN ONLY THE ALL ACCIDENT RIDER

6 EMPLOYMENT AND INCOME INFORMATION

6.1 Is the policyholder/insured retired, a student or a homemaker?

◯ Yes **IF YES**, proceed directly to Section 7 (non-medical Information)
◯ No **IF NO**, complete Section 6.2 before proceeding to Section 7 (non-medical Information)

THE POLICYHOLDER/INSURED MUST WORK IN AN INSURABLE OCCUPATION ACCORDING TO LA CAPITALE'S CRITERIA

6.2

SALARIED EMPLOYEE

Occupation: _____
Duties: _____
Employer's name: _____
Employer's address: _____
_____
Number of years with current employer: _____
Number of hours worked per week: _____
Number of months worked per year: _____
Gross annual income: $ _____

SELF-EMPLOYED AND BUSINESS OWNER

Occupation: _____
Duties: _____
Business name: _____
Business address: _____
_____
Number of years in business: _____
Number of years of related experience: _____
Number of hours worked per week: _____
If less than 30 hours worked per week, provide explanation:
_____
_____
Number of months worked per year: _____
Net annual income: $ _____

7 NON-MEDICAL INFORMATION

If any of the questions are answered "Yes" (except questions 1 and 5), complete the appropriate section of the additional questionnaire available in the illustration software or on lacapitale.com.

		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?	○	○
	3. Have you ever received treatment or counselling for alcoholism, alcohol abuse or have you been advised by a physician to reduce your alcohol consumption?	○	○
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 or are you awaiting the outcome of proceedings for a criminal offence?	○	○
	If yes, specify the type, date, sentence and probation for each offence.		
Driving record	Within the last 3 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 5 years, have you taken part in mountain climbing, motor vehicle racing, hang gliding, skydiving, scuba diving or any other hazardous sport or activity?	○	○

8 MEDICAL INFORMATION

		Yes	No
Medical information	1. Are you currently taking any medication?	○	○
Check YES or NO. Provide details for each YES answer in the "Explanations" section below.	2. Within the last 5 years, have you been hospitalized?	○	○
	3. Within the last 5 years, have you been advised to have a diagnostic test or undergo surgery that has not yet been done or has been done but the results not yet received?	○	○
	4. Within the last 5 years, have you received disability benefits from any source whatsoever?	○	○

Explanation

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

Question No.	Diagnosis, date of diagnosis, dates of consultations, reasons, results, medication or treatements, hospitalizations, surgery, names and addresses of physicians consulted or hospitals visited, current state of health or any other information.
_____	_____
_____	_____
_____	_____

Height and weight

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

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

If so, was the weight loss intentional? ○**Yes** ○**No**

If not, provide details: _____

How much weight did you lose? _____ ○kg ○lb

8 MEDICAL INFORMATION (CONT.)

Personal physician

Name of physician

Address

Tel. (extension)

Last physician consulted, if different — Date of last consultation: Year Month Day

Reason

Results (consultations or treatments recommended)

9 PAYMENT

9.1 SELECT PAYMENT METHOD

◯ Annual ◯ Preauthorized debit (PAD) ⚠ **Complete section 10.**

9.2 SELECT PAYMENT METHOD FOR THE INITIAL PAYMENT

◯ Payable by PAD **Available only if the selected method of premium payment is PAD.**

◯ Cheque attached to this application form $ _____ **Cheque must be made out to La Capitale Financial Security Insurance Company.**

◯ Credit card ⚠ **A La Capitale Financial Services Representative will contact the applicant to complete the credit card transaction.**

10 PREAUTHORIZED DEBIT (PAD) AGREEMENT

PREMIUM PAYOR'S INFORMATION

◯ Policyholder/insured ◯ Other: ◯ Mr. ◯ Ms. First name Last name

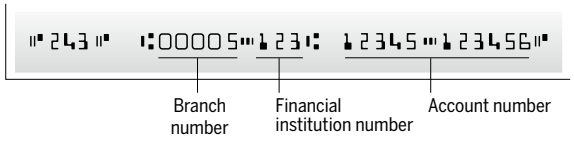
Address (No., street, apt., city, province) Postal code

Tel. Date of birth: Year Month Day

◯ Business: Company name Tel.

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

BANK ACCOUNT INFORMATION: ◯ Cheque specimen attached to the application ◯ Bank account information provided below:



Branch number Financial institution number Account number

PAD TYPE: ◯ Personal ◯ Business

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

I waive my right to receive advance notice of the amount and the date of the PAD and of any change to the amount and the date. I understand that a modal factor of .090 is applicable to monthly payments. This agreement may be cancelled upon receipt by the Insurer of 10 days' written notice prior to the scheduled date of the next PAD. To obtain a PAD cancellation form, or for more information about your right to cancel this agreement, contact your financial institution or visit www.cdnpay.ca. You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information about your recourse rights, contact your financial institution or visit www.cdnpay.ca. I authorize the Insurer or its agent to debit the fixed monthly amounts required for payments due to the Insurer from the account indicated on the enclosed cheque specimen or from the account identified above.

✗ _____ Signature of premium payor Date

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

11 DECLARATIONS AND AUTHORIZATIONS

I hereby confirm that the information provided in this application form is true and complete, in the knowledge that the Insurer shall base its decision to approve or decline my application form on this information and I further understand that any incomplete, inaccurate, false or deceitful declarations may cause my insurance contract to be cancelled.

I understand that if I am eligible, the insurance shall become effective on the date on which the Insurer approves this application form, provided that the initial payment has been paid and there have been no changes in the nature of the insurable risk of the policyholder/insured since the date on which the application form was signed. I further agree that the applicable premiums shall be those that are in effect on the date on which the application form is received by the Insurer.

I agree that the suicide of the policyholder/insured during the first two years following the effective date of any life insurance benefit issued for the policyholder/insured 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.

I hereby authorize any person, organization or public or parapublic institution holding personal information about me, including healthcare professionals, medical establishments, the MIB, LLC., financial institutions, insurance and reinsurance companies, personal information agents, investigation or consumer reporting agencies, my employer or my previous employers to disclose this information to the Insurer or to its reinsurers for the purposes of managing my file and considering my claims. I further authorize the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including the MIB, LLC., for such purposes.

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

A photocopy of this authorization is considered as valid as the original.

I acknowledge having read the leaflet or the illustration about Safe Driver, including guaranteed and non-guaranteed elements and any applicable exceptions and limitations. I acknowledge that my advisor has provided satisfactory explanations.

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

X _____
Policyholder/insured's signature

12 ADVISOR'S REPORT

12.1 ADVISOR'S INFORMATION

_____ | _____ | _____ | _____
Advisor's name | Advisor's code | General agent | General agent's code

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

12.2 COMMISSION STRUCTURE

Does not apply if the general agent has chosen a specific commission structure.

◯ Level ◯ High-low

12.3 COMMISSION SPLIT

Advisor's name	Advisor's code	Split	General agent	General agent's code
		%		
		%		
		%		
		%		

12.4 ADVISOR'S DECLARATIONS

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

I declare that I have provided all information about Safe Driver, including guaranteed and non-guaranteed elements and any applicable exceptions and limitations.

I declare that I hold all necessary licences and certificates for selling the insurance being applied for in the province or territory where it is being purchased.

In signing, I confirm that to the best of my knowledge all the information provided in this insurance application form is complete, accurate, and up to date.

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

X _____
Advisor's signature

☐ Check here if you would like the insurance policy to be mailed directly to the policyholder.