August 2021 version

La Capitale Financial Security

Pillar Series

Income Protection

Application

F002 (2021-08)

La Capitale

Application No.: 11665271

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

Contract No.: Leave this blank

1 BASIC INFORMATION

1.1 Language of correspondence: ◯ English ◯ French

1.2 Indicate if this is: ◯ a new application OR ◯ additional coverage to existing contract No.: _____

1.3 Should any contract resulting from this application be issued at the same time as another contract? ◯ Yes ◯ No

If so, indicate the number of the other application: _____

1.4 REASON FOR APPLICATION

☐ External replacement ⚠ **Complete and attach the prior notice of replacement.**

☐ Internal replacement Contract numbers being replaced: _____

⚠ **Complete and attach the prior notice of replacement and a request to cancel the existing insurance.**

2 GENERAL INFORMATION

2.1. POLICYHOLDER/INSURED'S INFORMATION

Last name _____ First name _____ Last name at birth (if different) _____

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

Marital status _____ Country of birth _____ In Canada since: ____ ____ (Year Month)

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

Address (No., street, apt.) _____

City _____ Province _____ Postal code ____ ____

Country _____ Email address _____

Home tel. ____ ____ ____ Work tel. ____ ____ ____ (extension) _____ Cell tel. ____ ____ ____

2.2 VERIFICATION OF POLICYHOLDER/INSURED'S 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/insured chooses to present one, it can be accepted.

ID Use original documents only.

◯ Driver's licence ◯ Passport ◯ Health Insurance card
◯ Other photo ID issued by a federal or provincial government: _____

Document No.: _____ Province or country of issue: _____

Expiry date (if available): ____ ____ (Year Month) Jurisdiction of issue: _____

3 CHOICE OF COVERAGE (This section must always be completed)

3.1 Indicate the same coverage as in the Illustration: ☐ Disability ☐ Safe Driver ☐ Hospital Care

3.2 Indicate the annual payment for all coverage and riders mentioned in the Illustration: $ _____

The premium may be subject to a provincial sales tax, if applicable.

I, the policyholder/insured, acknowledge that I have read the document entitled Illustration and agree to its contents. I confirm that the annual payment mentioned above corresponds to the annual payment mentioned in the Illustration.

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

POLICYHOLDER/INSURED'S SIGNATURE

✗ _____
Policyholder/insured's signature

ADVISOR'S SIGNATURE

✗ _____
Advisor's signature

⚠ **THE ILLUSTRATION THAT THE POLICYHOLDER/INSURED CONFIRMS HAVING READ MUST BE ATTACHED TO THE APPLICATION SENT TO THE INSURER.**

F002 (2021-08)

Application No.: 11665271

La Capitale

4 BENEFICIARY INFORMATION (For the **Accidental Death** rider or **Safe Driver** coverage)

A beneficiary is not designated: If a beneficiary is not designated, any benefit 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 designated. By naming a trustee, the benefit is payable to the trustee who will hold it in trust for the minor beneficiary until he or she is of legal age (not applicable in Quebec). In Quebec, the minor beneficiary's legal guardian will receive the payable benefit unless an official trustee has been named.

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

BENEFICIARY

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

5 PERSONAL INFORMATION

5.1 OTHER INSURANCE IN FORCE OR PENDING

Do you currently hold life, critical illness or accident or sickness disability insurance (including group or union insurance) or have a pending application for any of these types of insurance? ○ Yes ○ No **If so**, provide the details of these contracts or applications.

Company name	Year and month issued (check if pending) Year	Month	Pending	Life Insurance and Critical Illness Insurance: Insured amount	Accidental Death: Yes	No	DISABILITY: Monthly benefit	Elimination period: Accident	Elimination period: Sickness	Benefit period: Accident	Benefit period: Sickness	Will the insurance applied for replace the existing insurance contract? Complete the prior notice of replacement, if required.
			☐	$	○	○	$					○ Yes ○ No
			☐	$	○	○	$					○ Yes ○ No

5.2 PREVIOUS INSURANCE COVERAGE

Have you ever had a life (**LIFE**), critical illness (**CI**) or accident or sickness disability (**DI**) insurance application declined, deferred, modified, cancelled or rated with a higher premium? ○ Yes ○ No **If so**, provide details of these applications.

Year	Month	LIFE	CI	DI	Company name	Decision	Reason
		○	○	○			
		○	○	○			

5.3 PREVIOUS INSURANCE COVERAGE WITH LA CAPITALE FINANCIAL SECURITY INSURANCE COMPANY

Have you ever been insured by La Capitale Financial Security Insurance Company? ○ Yes ○ No

5.4. TOBACCO USE

In the last 12 months, have you smoked cigarettes, cigarillos, cigars, a pipe, a bong, a hookah or used betel nut, snuff or marijuana (cannabis) containing any tobacco or nicotine product or used any other form of tobacco or a substitute such as gum, nicotine patch or electronic cigarette? ○ Yes ○ No **If so**:

Type	Quantity	Frequency

If you quit smoking in the last 12 months, indicate the date: Year Month

F002 (2021-08)

6 EMPLOYMENT AND INCOME INFORMATION

6.1 EMPLOYMENT INFORMATION

Fill the *Occupation and Income Questionnaire (IND175E)* for any additional occupation.

SALARIED EMPLOYEE

6.1.1 Occupation: _____

6.1.2 Duties: _____

6.1.3 Employer's name: _____

6.1.4 Employer's address: _____

_____

6.1.5 Number of years with current employer: _____

6.1.6 Number of years of related experience: _____

6.1.7 Number of hours worked per week: _____

6.1.8 Number of months worked per year: _____

6.1.9 What percentage of your work is:

- Driving _____%
- Supervision _____%
- Office or administrative work _____%
- Manual work _____%
- Other: _____ _____%

6.1.10 What percentage of your work is done:

- At home _____%
- Away from home _____%

6.1.11 Gross annual income in the current year: $ _____

6.1.12 Do you pay Employment Insurance premiums? ◯ Yes ◯ No

6.1.13 a) Have you declared bankruptcy in the last 5 years? ◯ Yes ◯ No

b) **If so**, indicate the date you were discharged from bankruptcy: Year Month Day

6.1.14 Request for guaranteed benefit? ◯ Yes ◯ No

If so, provide your income tax declarations for the last 2 years and go to Section 7.

If not, go to Section 6.2.

SELF-EMPLOYED AND BUSINESS OWNER

6.1.1 Occupation: _____

6.1.2 Duties: _____

6.1.3 Business name: _____

6.1.4 Business address: _____

_____

6.1.5 Number of years in business: _____

6.1.6 Number of years of related experience: _____

6.1.7 Type of business: ◯ Sole owner ◯ Corporation ◯ Partnership

6.1.8 Number of employees:
Full-time: _____ Part-time: _____ Seasonal: _____

6.1.9 Number of hours worked per week: _____

6.1.10 Number of months worked per year: _____

6.1.11 What percentage of your work is:

- Driving _____%
- Supervision _____%
- Office or administrative work _____%
- Manual work _____%
- Other: _____ _____%

6.1.12 What percentage of your work is done:

- At home _____%
- Away from home _____%

6.1.13 What is the percentage of the policyholder/insured's interest in the company? _____%

6.1.14 Do you pay Employment Insurance premiums? ◯ Yes ◯ No

6.1.15 a) Have you (you or your business) declared bankruptcy in the last 5 years? ◯ Yes ◯ No

b) **If so**, indicate the date you were discharged from bankruptcy: Year Month Day

6.1.16 Request for guaranteed benefit? ◯ Yes ◯ No

If so, provide T1 General income tax forms and business financial statements for the last 2 years or the company's Statement of Business or Professional Activities, as applicable, and go to Section 7.

If not, go to Section 6.2.

6.2 INCOME INFORMATION

SALARIED EMPLOYEE

	Year:	Year:
Gross annual income earned in the last 2 years:	$	$

SELF-EMPLOYED AND BUSINESS OWNER

Net annual income in the last 2 years:[1]

If applying for a monthly benefit of $3,501 or more, provide T1 General income tax forms and business financial statements for the last 2 years or the company's Statement of Business Activities, as applicable.

	Year:	Year:
Net business profit[2]	$	$
In the case of a corporation, the salary paid to the policyholder/insured by the company, if applicable	+ $	+ $
	=	=
Net annual income	$ 0.00	$ 0.00

1. If less than 12 months' income earned, indicate number of months when income was earned: _____ months
2. Net business profit based on the policyholder/insured's shares = shares percentage × (business income before taxes − business expenses that are deductible for income tax purposes)

F002 (2021-08)

Application No.: 11665271

La Capitale

7 QUESTIONS FOR THE CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE

(Answer these questions only if the **Sickness Disability** rider is being applied for.)

		POLICYHOLDER/ INSURED	
		Yes	No
7.1	Have you ever consulted for, been treated for or shown signs or symptoms of the following? Heart or blood vessel disease, heart attack, chest pain, diabetes, cancer or tumours, transient ischemic attacks, stroke (cerebrovascular accident) or chronic kidney, liver or lung disease, multiple sclerosis, paralysis, blindness, deafness, loss of speech, loss of limbs, coma, severe burns, AIDS or HIV infection.	○	○
7.2	In the last 2 years, have you had any symptoms of or treatment for any medical condition that resulted in hospitalization (for any reason other than a pregnancy or childbirth)?	○	○
7.3	Have you had an application for individual or group life, disability, critical illness or long-term care insurance declined, deferred, modified, cancelled or rated with a higher premium?	○	○
7.4	In the last 90 days, have you been admitted or been advised to be admitted to a hospital or other medical facility (for any reason other than a pregnancy or childbirth)?	○	○
7.5	In the last 2 years, have you: a) been treated for or had any symptoms of disease or disorder of the neck, back or spine?	○	○
	b) been treated or counselled for anxiety, stress, "burnout", depression, chronic fatigue or an emotional, behavioural, mental or nervous disorder?	○	○
	c) been absent from work for more than 15 consecutive days as a result of an injury or sickness?	○	○
7.6	Are you unable to perform any duties of your present occupation because of injury or sickness?	○	○

8 PREMIUM PAYMENT

8.1 PAYMENT METHOD SELECTION

○ Annual ○ Semi-annual ○ Preauthorized debit (PAD) ⚠ **Complete Section 9.** ⚠ **If the bank account information is not provided, the Conditional Certificate of Temporary Insurance does not apply.**

8.2. SELECT PAYMENT METHOD FOR THE INITIAL PAYMENT

○ Cheque attached to this application $_____ 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.**

○ Cheque to be received on policy delivery. ⚠ **If this option is selected, the Conditional Certificate of Temporary Insurance does not apply.**

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

9 PREAUTHORIZED DEBIT (PAD) AGREEMENT

9.1 PREMIUM PAYOR INFORMATION

◯ Policyholder/insured ◯ Other: ◯ Mr. ◯ Ms. _____ _____
First name (please print) Last name (please print)

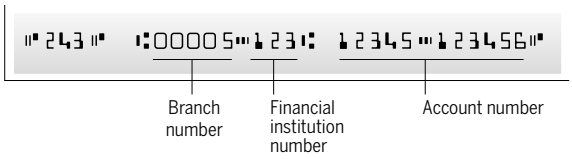
_____ _____
Address (No., street, apt., city, province) Postal code

_____ Date of birth: _____
Tel. Year Month Day

◯ Business: _____ _____
Name of business Tel.

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

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



Branch number _____ Financial institution number _____ Account number _____

9.3 PAD TYPE: ◯ Personal ◯ Business

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

9.5 WAIVER: I waive my right to receive advance notice of the amount and the date of the PAD and of any change to the amount and the date. I understand that a modal factor of .090 is applicable to monthly payments.

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

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

9.8 AUTHORIZATION: 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.

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

SIGNATURE OF PREMIUM PAYOR

X _____
Signature of premium payor

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

F002 (2021-08)

Application No.: 11665271

La Capitale

10 AUTHORIZATION TO DISCLOSE INFORMATION TO THE ADVISOR OR TO THE GENERAL AGENT

The policyholder/insured authorizes the Insurer to disclose to the advisor or to the general agent personal information collected in the application or during the underwriting process that may affect the premium rate or contract issuance. This information generally includes the results of medical or laboratory tests, medical, employment and alcohol or drug consumption history, criminal record, financial information or any other information considered when evaluating the application.

The Insurer may decide not to disclose this information to the advisor or the general agent even if this Authorization has been signed.

This Authorization will remain valid for 45 days after the contract is issued or a notice that the application was declined has been sent. This Authorization may be cancelled at any time by sending written notice to the Insurer.

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

POLICYHOLDER/INSURED

Last name and first name in printed letters

POLICYHOLDER/INSURED'S SIGNATURE

Policyholder/insured's signature

11 DECLARATIONS AND APPLICATION SIGNATURES

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

Subject to the general conditions of the contract and the conditions of the Conditional Certificate of Temporary Insurance, if issued, the policyholder/insured agrees 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 payment has been completed and that there have been no changes in the insurable risk of the policyholder/insured since the application was signed.

The policyholder/insured acknowledges having read and having receive a copy of the illustration containing information about the coverage applied for, including guaranteed and non-guaranteed elements and any applicable restrictions, reductions and exclusions. The policyholder/insured acknowledges that his or her advisor has provided satisfactory explanations.

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

The policyholder and the proposed insured acknowledge having received and read the MIB, Inc. Notice, the notice concerning investigations, medical examinations and tests, telephone or face-to-face interviews and the Personal Information Protection Notice,

The proposed insured authorizes the Insurer and its reinsurers for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes to have obtain and use any information held by a credit rating agency. This authorization remains valid for the length of time needed to achieve such purposes.

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

POLICYHOLDER/INSURED'S SIGNATURE

Policyholder/insured's signature

ADVISOR'S SIGNATURE

Advisor's signature

Contract No.: Leave this blank

12 AUTHORIZATION

1. For pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes, I hereby authorize any person, organization or public or parapublic institution holding personal information about me, including healthcare professionals, medical establishments, MIB, Inc., financial institutions, credit rating agencies, insurance and reinsurance companies, personal information agents, investigation or consumer reporting agencies, my employer or my previous employers to disclose this information to the Insurer or to its reinsurers. I further authorize the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including MIB, Inc., for such purposes.
2. For these same purposes, I authorize the Insurer and its reinsurers to request an investigation report relating to me and to make a brief report to MIB, Inc., providing personal information about my health.
3. This Authorization is also valid with regard to the collection, use and communication of personal information regarding my minor children, insofar as they are concerned by my application.
4. A photocopy of this Authorization is considered as valid as the original.

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

POLICYHOLDER/INSURED'S SIGNATURE

Policyholder/insured's signature

ADVISOR'S SIGNATURE

Advisor's signature

La Capitale Financial Security Insurance Company (the Insurer)

La Capitale
Financial Security

7150 Derrycrest Drive
Mississauga ON L5W 0E5

Application No.: 11665271

F002 (2021-08)

8 of 12

Application No.: 11665271

La Capitale

13 CONDITIONAL CERTIFICATE OF TEMPORARY INSURANCE

To be given to the policyholder/insured

The Conditional Certificate of Temporary Insurance (the Certificate) guarantees limited insurance coverage while the insurance application identified by the number at the bottom of this page is being reviewed by the Insurer. Being covered by the Certificate does not guarantee that the application will be accepted.

Effective date of the Certificate

The Certificate shall be effective when the following conditions are met:

- for the **sickness disability rider,** the policyholder/insured must have answered No to the questions for the Conditional Certificate of Temporary Insurance;
- the answers and explanations given in this application, any other form and interview must be complete and accurate;
- the first annual or semi-annual payment has been made or the Preauthorized Debit (PAD) Agreement has been duly completed and signed; and
- the policyholder/insured must not have asked that the contract's effective date be set for a specific subsequent date.

Subject to the above-mentioned terms and conditions, the Certificate shall be effective **on the later of the following dates**:

- the signature date of the duly completed application; or
- the date of completion of the last test, exam or telephone interview or declaration or form required prior to reviewing the application.

Termination of Certificate

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

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

Terms and exclusions

The Certificate does not apply to the following benefits and riders: Hospital Care, Safe Driver, Accident Hospitalization, Sickness Hospitalization, Accidental Death and Dismemberment, Accidental Fracture and the Future Insurability Option.

If the policyholder/insured enters a state of total disability while the 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 the policyholder/insured's insurable risk which may have occurred following the effective date of the Certificate. Therefore, in the event that, on the effective date of the Certificate, the Insurer would have issued a benefit covered by this Certificate, without any restrictions, exclusions or changes, the benefit shall be issued in accordance with the application.

If a benefit is issued pursuant to this Certificate, it shall be issued under the same terms and exclusions as the requested coverage, including the elimination period, subject to the terms and exclusions of the Certificate, with the latter taking precedence.

If the policyholder/insured does not enter a state of total disability while the Certificate is in force, any changes in the nature of the insurable risk regarding the policyholder/insured which may have occurred following the signature of the application shall be taken into consideration in order to determine if a benefit covered by this Certificate will be issued and, if so, under what terms.

No benefits shall be payable under the Certificate if the policyholder/insured is under age 18 or over age 59 on the date the application is signed.

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

The monthly total disability benefit payable under the Certificate, or any other certificate in force with the Insurer, corresponds to the lesser of:

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

No advisor may amend the terms of this Certificate.

In the event of a claim, the Insurer shall validate the eligibility of the policyholder/insured.

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

ADVISOR'S SIGNATURE

_____

Advisor's signature

F002 (2021-08)

La Capitale Financial Security Insurance Company (the Insurer)

14 NOTICE

To be given to the policyholder/insured

14.1 – MIB, Inc. Notice

Certain information must be collected when an insurer receives an application for insurance and such information must be as complete as possible. It may be medical, personal or involve your solvency.

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

Information about your insurability will be treated as confidential. However, La Capitale or its reinsurers may send a brief report concerning this information to MIB, Inc. (MIB), a non-profit organization that coordinates the exchange of information between member insurance companies. If you apply to another MIB member company for life or health insurance coverage, or submit a claim for benefits to such a company, MIB, upon request from this company, will disclose the information about you in its files.

If you submit a request, MIB will provide you with the information about you in its files. You can contact MIB by email at Canadadisclosure@mib.com or call 866 692-6901. If you dispute the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set out in the federal Fair Credit Reporting Act. The address of the MIB's information bureau is 50 Braintree Hill Park, Suite 400, Braintree, MA, 02184-8734, United States. Your information may be sent and warehoused outside of Canada and be governed by legislation applicable in foreign countries.

La Capitale, or its reinsurers, may also disclose your information from its files to other insurance companies to whom you may apply for life or health insurance, or to whom you may submit a claim for benefits. Consumers can obtain information about MIB by visiting its website at www.mib.com.

14.2 – Notice concerning investigations, medical examinations and tests, telephone or face-to-face interviews

In order to examine your application for insurance, the Insurer may wish to obtain some additional information.

Investigation: A representative from an investigation company may contact you to ask you for some personal and financial information.

Medical examination and tests: A physician or nurse from a paramedical company may ask you to undergo a medical examination, an electrocardiogram, chest X-ray or other diagnostic tests. Blood, urine or saliva samples may be taken. These samples may be analyzed to check for the presence of HIV antibodies, also known as the AIDS virus, determine your cholesterol level and screen for liver or kidney disorders, diabetes or the presence of nicotine, narcotics or prescription drugs.

You must give written consent before any samples are taken.

Your cooperation in ensuring any medical appointments are scheduled without delay is greatly appreciated.

Telephone or face-to-face interview: A telephone or face-to-face interview may be necessary to complete your application for insurance. If so, an evaluator working on behalf of La Capitale will contact you to schedule an appointment for a telephone or face-to-face interview, using the information given in the application. The interview will take from 20 to 30 minutes 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. The evaluator will not be able to let you know if you are eligible or not after the interview. The information obtained in the interview will be included with that stated in the application as well as any received from your physician.

14.3 – Notice concerning the Protection of Personal Information

The protection of your personal information is a priority for La Capitale. Your personal information is protected by high security standards, in accordance with the applicable laws and regulations regarding the protection of personal information.

Consent for the collection, communicating, use and storage of your personal information

La Capitale collects, communicates, uses and holds your personal information for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes, and this, for the length of time needed to achieve such purposes.

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

File purpose, storage location and access to your personal information

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

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

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

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

F002 (2021-08)

La Capitale Financial Security Insurance Company (the Insurer)

Application No.: 11665271

La Capitale

15 TELEPHONE INTERVIEW OR MEDICAL REQUIREMENT ORDERS

15.1. TELEPHONE INTERVIEW ORDER

Indicate the best time of day to reach the policyholder/insured.

	1ST CHOICE	2ND CHOICE
Day of the week:		
Time of day:	◯ morning ◯ afternoon ◯ evening	◯ morning ◯ afternoon ◯ evening
	Tel. _____ (extension)	Tel. _____ (extension)

◯ **Telephone interview to be ordered by the Insurer**

◯ **Telephone interview ordered from Dynacare by the advisor** To order a telephone interview from Dynacare, please dial 1 800 361-3771.

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

15.2 MEDICAL REQUIREMENTS ORDER

☐ HIV urine ☐ Blood profile ☐ Vital signs

◯ **Medical requirements to be ordered by the Insurer**

◯ **Medical requirements ordered by the advisor**

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

Medical requirements ordered from: ☐ ExamOne ☐ Dynacare

◯ **Medical requirements ordered by another insurer** – Specify the other insurer: _____

16 ADVISOR'S REPORT

If delivery has no requirements: ◯ **MAIL POLICY TO POLICYHOLDER/INSURED** ◯ **MAIL POLICY TO OFFICE**

16.1 Who initiated the application process? ◯ Advisor ◯ Policyholder/insured ◯ Acquaintance ◯ Another advisor ◯ Other: _____

16.2 Does the policyholder/insured speak or read the application language? ◯ Yes ◯ No

If not, who explained the application content to the policyholder/insured? _____

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

16.3 Did you complete this application in the presence of the policyholder/insured? ◯ Yes ◯ No

If not, explain: _____

16.4 Are you aware of any information that was not included in the application that could affect the underwriting process with regard to the policyholder/insured? ◯ Yes ◯ No **If so**, explain: _____

16.5 How long have you known the policyholder/insured? _____

16.6 What is the relationship between you and the policyholder/insured? _____

16.7 Have you completed and given the Conditional Certificate of Temporary Insurance to the policyholder/insured? ◯ Yes ◯ No

16.8. 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

16.9 COMMISSION STRUCTURE

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

◯ Level ◯ High-low

Continued on the next page > > >

16 ADVISOR'S REPORT (cont.)

16.10 COMMISSION SPLIT

Is the commission to be shared? ◯ Yes ◯ No **If so**, provide information on how the commission is to be shared.

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

16.11 SPECIAL INSTRUCTIONS

16.12 ADVISOR'S DECLARATION

I hereby declare that the information provided in this section is true.

I hereby declare that the benefits and riders mentioned in the Illustration attached to this application are the ones selected by the policyholder/insured. I further declare that I have provided all necessary explanations to the policyholder/insured.

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

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

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

ADVISOR'S SIGNATURE

X _____

Advisor's signature

INSTRUCTIONS FOR THE ADVISOR

- All required signatures must be entered.
- Any corrections or changes made to the application must be initialled by the policyholder/insured.
- Give the policyholder/insured the notices (section 14).
- Submit all of the application form pages except the pages that must be given to the policyholder/insured.

ATTACH THE FOLLOWING DOCUMENTS, AS APPLICABLE

In all cases	☐ Illustration
Replacement	☐ Prior notice of replacement ☐ Request to cancel existing insurance
PAD method of payment	☐ Preauthorized Debit (PAD) Agreement (Section 9) ☐ Cheque specimen or bank information. **If the bank account information is not provided, the Conditional Certificate of Temporary Insurance does not apply.**
Annual or semi-annual method of payment	☐ Cheque made out to La Capitale Financial Security Insurance Company. **If the cheque is received upon delivery of the policy, the Conditional Certificate of Temporary Insurance does not apply.**

F002 (2021-08)

Application No.: 11665271

La Capitale