beneva

Insurance Application – MaturHealth / MaturLife / AcciGuard

Beneva Inc., 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

Policy number _____ **Application number** _____

General Information

Type of request

☐ New application ☐ Addition to the policy ☐ Policy change or cancellation (complete Sections 1, 2, 3, 4, 5, 6, 7 or 8, 9, 13, 17, 18,19, 20 and 21)
☐ Reinstatement ☐ Other: _____

Section 1: Eligibility Requirements

At the time of applying for insurance and on the effective date, the proposed insured must meet the insurability standards of Beneva Inc. and the following eligibility requirements (for the MaturHealth and MaturLife benefits, please complete questions 1 to 3, and for the AcciGuard benefit, please complete questions 1 to 4):

1. The proposed insured must be a Canadian citizen or a landed immigrant; are you eligible on the basis of this requirement? ☐ Yes ☐ No
2. The proposed insured must have been residing in Canada for at least two (2) years; are you eligible on the basis of this requirement? ☐ Yes ☐ No
3. The proposed insured must not be hospitalized or staying in a medical or convalescent facility; are you eligible on the basis of this requirement? ☐ Yes ☐ No
4. For the **AcciGuard** benefit **only**: the proposed insured **must not be in a state of total and permanent disability or in total disability**; are you eligible on the basis of this requirement? ☐ Yes ☐ No

Section 2: Note Concerning Disability

If a proposed insured has been declared totally and permanently disabled or is currently totally disabled, he/she may not be covered under a plan with monthly disability benefits.

Are you totally and permanently disabled or are you currently totally disabled? ☐ Yes ☐ No

Section 3: Proposed Insured

First name _____ Last name _____

Name at birth (if different) _____ Date of birth (D D M M Y Y Y Y) _____ Age _____ Sex ☐ Female ☐ Male

Address (civic number and street name) _____ Apt. _____ City _____

Province _____ Postal code _____ Telephone (home) _____ Smoker ☐ Yes ☐ No

Occupation (position) _____ Telephone (work) _____

Employer _____ $ _____ /year Gross income

Section 4: Policyowner (Complete if the policyowner is not the proposed insured)

First name _____ Last name _____

Name at birth (if different) _____ Date of birth (D D M M Y Y Y Y) _____ Relationship to proposed insured _____

Address (civic number and street name) _____ Apt. _____ City _____

Province _____ Postal code _____ Telephone _____

Company or trust: _____ Business number _____
Full legal name

Subsidiary policyowner (if needed)

First name _____ Last name _____

Date of birth (D D M M Y Y Y Y) _____ Relationship to proposed insured _____

Section 5: Other In Force Insurance Policies (Individual And Group) ☐ Check box if no insurance is in force

Company Name	Type of Coverage	Policy Number	Issue Year	Benefit Amount or Insured Amount
				$
				$
				$
				$

Section 6: Replacement

Does this application replace any individual policy in force?

☐ Yes ☐ No If yes, the prior notice(s) of replacement must be completed and submitted, in accordance with the terms applicable to each province, with the present application or in the delay prescribed by each province.

Application number _____

Section 7: Modification of Benefit(s)

For an increase of the benefit period or a reduction of the waiting period, please also complete Section 15: Medical Questionnaire (for MaturHealth only).

Name of Benefit	Benefit Period	Waiting Period	Benefit Amount or Insured Amount (reduction only)	New Premium
	From: to:	From: to:	From: to:	$
	From: to:	From: to:	From: to:	$

Section 8: Benefit or Policy Cancellation

Policy Number	Insured's Name (if applicable)	Policy Cancellation (all benefits)	Partial Cancellation (specific benefit to cancel)
		☐	
		☐	
		☐	

Section 9: Market

Type of Applicant	Member ID Number	Association Name	Association Number
☐ **Public** (group 100)			
☐ **FADOQ** (group 300)			

Section 10: Benefits Requested MaturHealth – accident and sickness insurance

Name of the Benefit	Benefit Period	Waiting Period	Benefit Amount or Insured Amount	ROP	Modal Premium
☐ Home Convalescence Benefit (34)	☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days	☐ 7 days ☐ 14 days ☐ 30 days	$ / month	☐	$
☐ Home Convalescence Benefit with Additional Cancer Treatment Coverage (20)	☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days	☐ 7 days ☐ 14 days ☐ 30 days	$ / month	☐	$
☐ Medical Care (at home or in clinic) (35)				☐	$
☐ Ambulatory Care and Paramedical Emergency Call System Benefit (22)			☐ $25 / visit ☐ $50 / visit	☐	$
☐ Benefit in case of Fracture (FRA)			☐ $5,000 ☐ $10,000	☐	$
☐ Hospital Benefit (31)			$ / day	☐	$
☐ Benefit for Stay in Convalescence Centre (38)	☐ 30 days ☐ 60 days		$ / day	☐	$
☐ Drugs Benefit Following Hospitalization (33)				☐	$
☐ Inpatient Rehabilitation Benefit (32)			$ / day	☐	$
☐ Extended Health Care Benefit (37)				☐	$
☐ Accidental Disability Monthly Benefit (ACC)	☐ 180 days ☐ 365 days		$ / month	☐	$
☐ Cancer Benefit (CAN)			☐ T10 $ _____ ☐ T20 $ _____	☐	$
☐ Critical Illness Rider (CI)			☐ T10 $ _____ ☐ T20 $ _____	☐	$
☐ Critical Illness Rider Plus Rider (CIP)			☐ T10 $ _____ ☐ T20 $ _____	☐	$
☐ Accidental Death and Dismemberment Benefit (AD&D)			☐ $25,000 – $50,000 ☐ $50,000 – $100,000	☐	$
			Basic Contractual Premium		**$**
			Total MaturHealth Premium		**$** 0.00

Application number _____

Section 11: Benefits Requested MaturLife – Life insurance

Name of the Benefit	Insured Amount	Modal Premium	Contractual Premium	Total Modal Premium
☐ MaturLife	$	$	$	$
☐ MaturLife *privilege* ☐ Deferred option	$	$	$	$
			Total Life Insurance Premium	$ 0.00

Beneficiary(ies) for MaturLife / MaturLife *privilege* Benefit

If you selected the MaturLife and/or MaturLife privilege benefit, please indicate both the first name and the last name of the person(s) who will receive the sums insured when they become payable under the MaturLife and/or MaturLife privilege benefit. **If more than one beneficiary is designed, the total unit allocation should equal 100%.**

The beneficiary designations are revocable, unless the **Irrevocable** box is selected. In Quebec, the designation of the policyowner's married or civil union spouse as beneficiary is irrevocable unless the **Revocable** box is selected.

If the primary beneficiary predeceases the proposed insured, the sums insured are payable to the contingent beneficiary upon the death of the proposed insured.

If there is no designated beneficiary at the death of the insured, the policyowner shall be the beneficiary, or in the case where the policyowner and the proposed insured are the same person, the estate of the policyowner shall be the beneficiary.

Primary Beneficiary(ies) 1

	Last name	First name	Relationship to the proposed insured (in Quebec, relationship to the policyholder)	Check one box Revocable	Irrevocable	Share % Total 100%
1				☐	☐	
2				☐	☐	

Contingent(s) beneficiary(ies) 1
- In case of death of the beneficiary(ies) designated above, the percentage is equivalent.

	Last name	First name	Relationship to the proposed insured (in Quebec, relationship to the policyholder)	Check one box Revocable	Irrevocable
1				☐	☐
2				☐	☐

Trustee for a minor beneficiary (not applicable in Quebec)
- When a minor is designated as beneficiary, it is suggested that a trust be constituted for claims purposes (not applicable in Quebec).
- If a trust is constituted, complete the information below.

Last name of minor beneficiary	First name of minor beneficiary	Last and first name of trustee	Relationship to the proposed insured

Primary Beneficiary(ies) 2

	Last name	First name	Relationship to the proposed insured (in Quebec, relationship to the policyholder)	Check one box Revocable	Irrevocable	Share % Total 100%
1				☐	☐	
2				☐	☐	

Contingent(s) beneficiary(ies) 2
- In case of death of the beneficiary(ies) designated above, the percentage is equivalent.

	Last name	First name	Relationship to the proposed insured (in Quebec, relationship to the policyholder)	Check one box Revocable	Irrevocable
1				☐	☐
2				☐	☐

Trustee for a minor beneficiary (not applicable in Quebec)
- When a minor is designated as beneficiary, it is suggested that a trust be constituted for claims purposes (not applicable in Quebec).
- If a trust is constituted, complete the information below.

Last name of minor beneficiary	First name of minor beneficiary	Last and first name of trustee	Relationship to the proposed insured

Section 12: Benefit(s) Requested AcciGard – Accident insurance

Name of Benefit	Basic Indemnity		Benefit Period		Modal Premium
Disability due to accident benefit	☐ $500 / month	☐ $1,000 / month	☐ 6 months	☐ 12 months	$
Hospitalization due to accident benefit	☐ $50 / day	☐ $100 / day			$
Accidental death and dismemberment benefit	☐ $25,000 - $50,000	☐ $50,000 - $100,000			$
Benefit in case of fracture	☐ $5,000	☐ $10,000			$
				Basic Contractual Premium	**$**
				Total AcciGuard Premium	$ 0.00

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Section 13: Premium Payment

Payment frequency ☐ Annual ☐ Monthly (pre-authorized debits - complete Section 17)

1st premium payment

☐ Cheque enclosed ☐ Pre-authorized debit (monthly payment frequency only)

Date of the cheque | D | D | M | M | Y | Y | Y | Y |
Cheque payable to Beneva Inc.

Date of the 1st pre-authorized debit | D | D | M | M | Y | Y | Y | Y |
The 1st pre-authorized debit will be on the latest of the following dates: the Monday following the above-mentioned date and the Monday following the reception of the application at Beneva Inc.

The first premium payment will be cashed on reception of this application if no other date is specified above. The payment of the first premium by pre-authorized debit will be withdrawn from the bank account indicated in Section 17 and appearing on the specimen cheque attached to this application.

Day of withdrawal

If left blank, the day of withdrawal will be the issue date of the policy.

☐ Day of withdrawal at issue date OR ☐ Specify the day: _____

If the day of withdrawal specified is the 29th, 30th or 31st, the day of withdrawal will be the 28th.

Addition to the policy

☐ Cheque enclosed ☐ Pre-authorized debit

Date of the cheque | D | D | M | M | Y | Y | Y | Y | Cheque payable to Beneva Inc.

Proportional premium	$
Renewal premium	$
Total modal premium of requested benefits	$
Total amount paid	**$** 0.00

Section 14: Notice to the proposed insured and policyowner(s)

Notice regarding personal files and personal information

Beneva Inc. advises the proposed insured that all information obtained for risk assessment, premium calculations and the investigation or adjudication of any claim is stored in a file referred to as "**Life and Health Insurance**". Only the employees, representatives or agents of Beneva Inc. and persons authorized by the proposed insured have access to this file when needed to exercise their duties, execute their mandates or as authorized by the proposed insured. This file is maintained at the office of Beneva Inc. The proposed insured is entitled to have access to the personal information in this file and, if applicable, to rectify any inconsistencies. To do so, a written request must be sent to the attention of the Access Officer, Beneva Inc. at 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9.

Section 15: Medical Questionnaire

This section applies to the following benefits:

1. **Accident and Sickness benefits** - complete Part 1. For Acciguard guarantees, complete Section 1 only.
2. **Accidental Disability and AD&D benefit** - complete Part 2
3. **Benefit in case of Accidental Fracture** - complete Part 3
4. **MaturLife benefit** - complete Part 4
5. **MaturLife *privilege* benefit** - complete Part 5

Part 1 – Accident and Sickness	**Yes**	**No**
1. a) In the past two (2) years, have you been or have you been advised to be:		
- hospitalized or treated surgically for cardiovascular or cerebrovascular problems?	☐	☐
- hospitalized or treated surgically or otherwise for cancer or a malignant tumour?	☐	☐
b) In the past two (2) years, have you undergone or has a physician advised you to undergo cancer screening tests for which the results are not yet known or that have revealed the presence of cancer?	☐	☐
2. Have you ever been diagnosed with acquired immune deficiency syndrome (AIDS), any AIDS-related complex (ARC), any other disorder of the immune system or undergone tests for which the results were seropositive with regard to the human immunodeficiency virus (HIV)?	☐	☐
3. Do you have or have you ever had a respiratory or lung disease requiring the use of a respiratory device other than CPAP?	☐	☐
4. In the past five (5) years, have you used or do you use narcotics, cocaine or other drugs (excluding cannabis), or have you ever been treated for alcohol or drug abuse, or have you received counselling in that regard?	☐	☐
5. Are you currently in need of a third party's assistance to perform any of the following activities: a) eating b) dressing c) going to the toilet d) washing or personal hygiene e) transferring from bed to an armchair	☐	☐
6. Do you have any of the following conditions: a) cirrhosis of the liver b) vascular dementia c) hepatitis C d) Alzheimer's disease e) Parkinson's disease	☐	☐
7. Have you had an epileptic seizure in the past five (5) years?	☐	☐
8. a) If you suffer from diabetes, have you been diagnosed by a physician or an ophthalmologist for visual disturbances and/or eye problems or for kidney problems linked to your diabetes?	☐	☐
b) If you suffer from diabetes, have you had an amputation related to your diabetes in the past five (5) years?	☐	☐
c) Are you insulin-dependent?	☐	☐
9. In the past two (2) years, have you had your driver's licence suspended for any reason other than a medical reason?	☐	☐
For the Extended Health Care Benefit (MS37) also answer question 10:		
10. Do you have or have you ever had a respiratory or lung disease requiring the use of a respiratory device?	☐	☐
Part 2 – Accidental Disability and AD&D (if the questions in Part 1 have all been answered, it is not necessary to complete Part 2)	**Yes**	**No**
1. In the past two (2) years, have you had your driver's licence suspended for other than medical reasons?	☐	☐
Part 3 – Accidental Fracture	**Yes**	**No**
1. In the past two (2) years, have you had your driver's licence suspended for other than medical reasons?	☐	☐
2. Have you been diagnosed by a physician for osteoporosis or disc degeneration?	☐	☐

Section 15: Medical Questionnaire (continued)

Part 4 – MaturLife	Yes	No
1. Are you presently hospitalized or bedridden in a clinic, a hospital, a long-term care facility or a facility people with loss of physical or mental autonomy?	☐	☐
2. In the past two (2) years, have you been diagnosed or treated for any form of cancer or malignant tumour (other than basal cell carcinoma)?	☐	☐
3. Have you been diagnosed with acquired immune deficiency syndrome (AIDS) or any AIDS-related complex (ARC) or undergone tests for which the results were seropositive with regard to the human immunodeficiency virus (HIV)?	☐	☐
4. In the past twelve (12) months, have you used tobacco or consumed any product containing nicotine such as cigars, cigarillos, cigarettes, marijuana/cannabis with tobacco, electronic cigarettes, vaping products, pipes, nicotine gum or patches? **If the answer is "No", the premium class will be NON-SMOKER. If the answer is "Yes", the premium class will be SMOKER.**	☐	☐
For a sum insured greater than $35,000, the following questions must also be answered.		
5. In the past two (2) years, have you had an application for life insurance declined or postponed?	☐	☐
6. In the past two (2) years, have you been hospitalized for one of the following conditions: angina, heart attack, heart failure or cardiomyopathy?	☐	☐
7. In the past five (5) years, have you received a diagnosis or undergone treatment for diseases such as amyotrophic lateral sclerosis (Lou Gehrig's disease), progressive bulbar paralysis, or any other incurable terminal illness?	☐	☐

Part 5 – MaturLife *privilege*	Yes	No
1. In the past twelve (12) months, have you used tobacco or consumed any product containing nicotine such as cigars, cigarillos, cigarettes, marijuana/cannabis with tobacco, electronic cigarettes, vaping products, pipes, nicotine gum or patches? **If the answer is "No", the premium class is NON-SMOKER. If the answer is "Yes", the premium class will be SMOKER.**	☐	☐
2. In the past two (2) years, have you had an application for life insurance declined or postponed other than group insurance or group mortgage insurance? **If you answered "Yes" to question 2**, you unfortunately do not qualify for MaturLife *privilege*, however, you may qualify for the MaturLife privilege deferred option if you answer "**No**" to all of the following questions.	☐	☐
3. Are you presently hospitalized or bedridden in a clinic, a hospital, a long-term care facility or a facility for people with loss of physical or mental autonomy?	☐	☐
4. In the past two (2) years, have you been diagnosed, hospitalized or treated (other than by medication) for any of the following conditions:		
a) Any form of cancer or malignant tumour (other than basal cell carcinoma)	☐	☐
b) Angina, heart attack, heart failure or cardiomyopathy	☐	☐
c) Stroke	☐	☐
d) Chronic respiratory disease necessitating the administration of oxygen	☐	☐
e) Chronic kidney disease	☐	☐
f) Diabetic coma or insulin shock	☐	☐
5. In the past two (2) years, have you been prescribed a new medication or required a change in dosage in your medication for any of the following conditions:		
a) Any form of cancer or malignant tumour (other than basal cell carcinoma)	☐	☐
b) Angina, heart attack, heart failure or cardiomyopathy	☐	☐
c) Chronic kidney disease	☐	☐
6. Have you ever been diagnosed or treated for the following conditions:		
a) Alzheimer's disease or dementia	☐	☐
b) Amyotrophic lateral sclerosis (Lou Gehrig's disease)	☐	☐
7. In the past five (5) years, have you received an organ transplant or a bone marrow transplant or were you advised that one was required due to your condition?	☐	☐
8. Have you been diagnosed with acquired immune deficiency syndrome (AIDS) or any AIDS-related complex (ARC) or undergone tests for which the results were seropositive with regard to the human immunodeficiency virus (HIV)?	☐	☐
9. Have you been diagnosed or treated for any incurable terminal illness for which you have been advised that you have less than twelve (12) months' life expectancy?	☐	☐

Section 16: Declaration of Insurability

This section applies to the following benefits:

1. **Cancer Benefit** – The proposed insured must respect the statements in Part 1 to be eligible for the Cancer Benefit.
2. **Critical Illness Rider** – The proposed insured must respect the statements in Part 1 and Part 2 to be eligible for the Critical Illness Rider.
3. **Critical Illness Plus Rider** – The proposed insured must respect the statements in Part 1, Part 2 and Part 3 to be eligible for the Critical Illness Plus Rider.

Part 1 – Cancer Benefit, Critical Illness Rider and Critical Illness Plus Rider

1. I declare that during my lifetime:
   a) I have not had a cancer or malignant tumour diagnosis, exhibited signs or symptoms of cancer, consulted a physician or undergone tests for which the results were abnormal with regard to cancer; I am not awaiting a test or an examination prescribed by a physician concerning cancer and I have not undergone tests with regard to cancer for which I am awaiting the results;
   b) I have not received a diagnosis of acquired immune deficiency syndrome (AIDS) or undergone tests for which the results were seropositive with regard to the human immunodeficiency virus (HIV).
2. If I selected the non-smoker option, I declare that I have not used any tobacco products or nicotine containing products such as cigars, cigarillos, cigarettes, marijuana/cannabis with tobacco, electronic cigarettes, vaping products, pipes, nicotine gum or patches in the last twelve (12) months.

Part 2 – Critical Illness Rider and Critical Illness Plus Rider

3. I declare that to this date, I have never been diagnosed, exhibited symptoms, consulted a physician, undergone a test for which the results were abnormal or been awaiting a test for the following conditions:
   a) Angina, heart attack (myocardial infarction), chest pain, heart failure, stroke, transient ischemic attack, abnormal EKG or any other disorder of the heart or circulatory system
   b) Diabetes
   c) Hepatitis
   d) Chronic renal failure
4. I confirm that, in the last five (5) years, I have not used narcotics, cocaine or any other drugs (excluding cannabis), or had to undergo treatment for alcohol or drug abuse, or receive counselling for this problem.
5. I confirm that at most one of my immediate family members (father, mother, brother, sister) has suffered, before the age of sixty (60), from a heart attack (myocardial infarction), stroke, diabetes or transient ischemic attack (TIA).
6. I confirm that my current weight does not exceed the maximum weight according to my height indicated in the table below:

Height		Maximum Weight		Height		Maximum Weight	
Feet	Centimetres	Pounds	Kilograms	Feet	Centimetres	Pounds	Kilograms
5'0" and less	152 cm and less	173	78	5'9"	175 cm	229	104
5'1"	155 cm	179	81	5'10"	178 cm	236	107
5'2"	157 cm	185	84	5'11"	180 cm	243	110
5'3"	160 cm	191	87	6'0"	183 cm	250	113
5'4"	163 cm	197	89	6'1"	185 cm	257	117
5'5"	165 cm	204	93	6'2"	188 cm	264	120
5'6"	168 cm	210	95	6'3"	191 cm	271	123
5'7"	170 cm	216	98	6'4"	193 cm	278	127
5'8"	173 cm	223	101	6'5" and more	196 cm and more	286	130

Part 3 – Critical Illness Plus Rider

7. I confirm that I am not currently hospitalized or bedridden in a clinic, a hospital, a long-term care facility or a facility for people with loss of physical or mental autonomy.
8. I declare that I can perform all of the following activities without a third party's assistance:
   a) eating b) dressing c) going to the toilet d) washing myself e) getting in or out of bed
   Furthermore, I declare that I am continent.
9. I declare that to this date, I have never been diagnosed, exhibited symptoms, consulted a physician, undergone a test for which the results were abnormal or been awaiting a test for the following conditions:
   a) Multiple sclerosis, Alzheimer's disease, Parkinson's disease, motor neuron disease, paralysis, dementia or any other brain condition or neurological disorder
   b) Muscular dystrophy
   c) Amyotrophic lateral sclerosis (Lou Gehrig's disease)
10. I confirm that, in the last five (5) years, I have not had an epileptic seizure.
11. I confirm that none of my immediate family members (father, mother, brother, sister) have had, before the age of sixty-five (65), Alzheimer's disease, Parkinson's disease, dementia or motor neuron disease.

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Section 17: Pre-Authorized Debit Agreement

1. I hereby authorize Beneva Inc. to debit my account as per my instructions and/or as detailed in the contract of insurance, for monthly (or annually) recurring payments and/or one time payments from time to time, in payment of all charges, including any applicable financing charges and taxes, arising from the contract of insurance.
2. The amount of the pre-authorized debit may be increased or decreased at a later date as a result of endorsements, cancellation, exclusions or renewal of the contract of insurance. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as variable amount pre-authorized debits. I understand that the same method of payment will apply upon renewal of the contract of insurance, if applicable, unless I notify Beneva Inc. before the renewal date of the contract of insurance.
3. I understand that depending on the product chosen, a monthly payment will result in a higher annualized premium.
4. If a pre-authorized payment is returned due to insufficient funds (NSF), Beneva Inc. is authorized to re-submit the payment. Any charges incurred as a result of NSF may be added to the subsequent pre-authorized payment.
5. I agree to inform Beneva Inc., by way of a letter, of any change in the account information provided in this Agreement at least ten (10) business days prior to the next debit to my account.
6. I agree to the debiting of my account each month (or each year) on the day selected in the insurance application or the next business day.
7. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as Personal.
8. **I agree and understand that Beneva Inc. will not notify me before each withdrawal.**
9. In the event that I instruct Beneva Inc. to change the amount of the pre-authorized debit, I waive the right to receive the required notice.
10. I may cancel this authorization for pre-authorized debits at any time, subject to providing Beneva Inc. with thirty (30) days notice in writing. I may contact my financial institution about my rights regarding cancellation, or visit www.cdnpay.ca for a sample cancellation form.
11. I understand that Beneva Inc. reserves the right to terminate this Agreement upon fifteen (15) days notice in writing.
12. Any cancellation of this Agreement will not terminate or otherwise have any bearing on any Agreement that exists with Beneva Inc. whatsoever with respect to any contract of insurance, so long as payment is provided by an alternate method accepted by Beneva Inc.
13. I have certain recourse rights if any debit does not comply with this Agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Beneva Inc.
Premium Accounting
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

Please attach a cheque specimen,
on which you have written "CANCELLED",
for the account to be debited.

Name of financial institution

Address, city, province and postal code of the branch

Branch

Financial institution number

Account number

Authorization

Is the account used a joint account? ☐ **Yes** ☐ **No**

For a joint account, all account holders must sign if more than one signature is required on cheques issued from the account.

Name of account holder or authorized person (please print)

X _____
Signature

D D M M Y Y Y Y
Date

Name of account holder or authorized person (please print)

X _____
Signature

D D M M Y Y Y Y
Date

Section 18: Notice to proposed insured(s) and policyowner(s)

Notice regarding the protection of your personal information

Protecting your personal information is a priority for Beneva[1]. For this reason, we want to inform you that we collect, use and disclose your personal information only with your consent, unless otherwise permitted by law, and only for the time necessary to:

- identify you
- establish and update your profile, needs and objectives
- evaluate your applications and eligibility for our products and services
- provide you with advice related to your situation
- administer your contracts as well as your products or services (e.g. : pricing, underwriting, enrolment, claims processing, etc.)
- comply with legal and regulatory requirements (e.g. : preventing, detecting or deterring violations, cyber threats, fraud, etc.)
- obtain your feedback on our products and services
- provide you with personalized offers and advice about our products and services (refer to your right to withdraw consent) based on your preferences and in compliance with the rules governing electronic and telephone communications
- conduct studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you

How does Beneva collect your personal information?

We may collect your personal information over the telephone, in person, and through the use of our forms and our digital platforms.

Who does Beneva share your personal information with?

For the purposes described above, and only in connection with your products and services, we share your personal information with our affiliates and distribution networks and with third parties, some of which may be located outside of Quebec and Canada.

These third parties may include:

- other financial institutions, such as insurers and reinsurers
- other organizations or entities that have information about you, including insurance, fraud or claims information
- intermediaries
- credit assessment agencies
- government departments, agencies or regulatory authorities
- employers
- claims-related service providers, such as healthcare professionals and auto repair shops
- other agents and service providers (technology services, printing and mailing services, etc.)

Please note that in all cases, we ensure that they respect the protection of your personal information.

What are your rights regarding access and rectification?

You may access your personal information or request the correction of incomplete or inaccurate information. Send us a request to the following address:

Personal Information Protection Officer

Beneva
625 rue Jacques-Parizeau
Quebec QC G1R 2G5

ResponsablePRP@beneva.ca.

For more information about our personal information protection practices, please refer to the complete version of our Personal Information Protection Statement at www.beneva.ca.

Your consent for the collection, use and disclosure of your personal information is necessary in order to provide the product or service requested or offered. You have the right to withdraw your consent, but Beneva will not be able to continue providing you with its products or services.

For the sole use of Beneva financial advisors (BFA)

Consent to receive personalized product offers and advice on products and services (optional)
I consent to the necessary collection, use and disclosure of my personal information by Beneva to service providers as well as websites and applications belonging to third parties to receive personalized offers and advice on products or services.
I understand that I may withdraw my consent by calling 1 844 781-0860 or visiting Beneva.ca

☐ Policyowner 1 ☐ Policyowner 2

1. The term "Beneva" refers to Beneva Inc., its affiliates and their mutual insurance companies and distribution networks. Affiliates of Beneva Inc. designates La Capitale Financial Security Insurance Company, Beneva Investment Services Inc., Beneva Insurance Company Inc., L'Unique General Insurance Inc. and Unica Insurance Inc.

Section 19: Declarations

The undersigned:

1. Certify having reviewed the eligibility requirements set forth in Section 1: Eligibility Requirements and declare that the proposed insured is eligible on the basis of such requirements.
2. **Declare that no coverage with monthly disability benefits has been applied for if the proposed insured is totally and permanently disabled or is totally disabled.**
3. **Declare having reviewed the EXCLUSIONS and LIMITATIONS applicable to the benefits and contained in the MaturHealth and/or MaturLife brochure for which they confirm having received a copy.**
4. Declare that all of the answers provided in this document are true and complete, have been correctly recorded and form part of the insurance application with Beneva Inc. The undersigned consent to such answers being used to serve as the basis for the insurance policy being applied for or the change requested. Any misrepresentation or concealment by the proposed insured regarding circumstances that are known to the proposed insured and likely to have a material influence on a reasonable insurer with respect to setting of premium, the appraisal of risk or the decision to cover it, shall cause the contract, at the request of Beneva Inc., to become void even with respect to any losses not connected with the risks so misrepresented or concealed.
5. Certify that the statements contained in Section 16: Declaration of Insurability are true.
6. **Declare having reviewed that Beneva Inc. does not take upon any obligation unless this request has been signed by the proposed insured, the policyowner and the authorized representative / financial security advisor, the initial premium has been paid, and the application and corresponding medical questionnaire have been approved by Beneva Inc.**
7. Declare having been made aware that Beneva may gather personal information using technology that has identification, localization and profiling features, which are necessary for evaluating applicants. This is the case for the electronic application, which is used to assess a person's risk profile in order to provide the best possible premium. The undersigned agree that submitting an application initiates this process.
8. Declare having been made aware that Beneva may use their personal information to make entirely automated decisions (i.e. no human intervention). For example, in the case of an electronic application, an automated decision may be made in an effort to accelerate the underwriting process, including premium calculation and risk selection.
9. Declare having been made aware of the personal information protection notice as well as of all other notices sent to the applicant(s) and the owner(s) as well as having accepted the terms and conditions herein.
10. **Declare having reviewed the following: Any new application becomes effective on the date when it is accepted by Beneva Inc., provided that it is accepted without modification, that the initial premium has been paid and that there has been no change in the proposed insured's insurability between the date the application was signed and the effective date of the policy. Any benefit modification request or addition of benefit(s) request to the policy becomes effective on the day of the month of the policy following the date the request is accepted by Beneva Inc. on the condition that the modification request or the addition of benefit(s) request is accepted without change, that the premium has been paid and that there has been no change in the proposed insured's insurability between the date the modification request or the addition of benefit(s) request has been signed and the date the modification request or addition of benefit(s) came into force. Any benefit cancellation request becomes effective on the day of the month of the policy following the date the request is received by Beneva Inc.**

_____
Signed at (city and province)

D D M M Y Y Y Y
Date

X _____
Signature of proposed insured

X _____
Signature of policyowner

Application number _____

Section 20: Authorizations

Your authorizations are necessary in order to provide and administer your products and services.

1. Authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.
2. Authorize Beneva Inc. and its reinsurers to gather, use and provide, for the purposes indicated in the protection of personal information notice, to all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history and lifestyle habits. This authorization is valid for the specific period required to process the request. A photocopy or digital version of this authorization is as valid as the original.
3. Authorize Beneva Inc. and its reinsurers to gather personal information from a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is valid for the specific period required to process the request.
4. Authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and consents required to obtain the necessary proof and process the death benefit claim.

Insured

I acknowledge having read the 4 authorizations above-mentionned and agree to them.

Name of Insured (please print)	X Signature of Insured	D D M M Y Y Y Y Date
If a minor insured: Name of mother, father or legal guardian (please print)	X If a minor insured: Signature of mother, father or legal guardian (indicate relationship to the insured)	D D M M Y Y Y Y Date

Section 21: Declarations and Signature(s) of the Representative / Financial Security Advisor and Supervisor

Name of authorized representative / financial security advisor (please print)	Share %	Code	
Name of authorized representative / financial security advisor sharing commission (please print)	Share %	Code	☐ Reference
Name of supervisor (please print)	X Signature of supervisor		

I confirm that I have provided an "**Advisor Disclosure Statement**" to the policyowner disclosing the following:
• the name of the company or companies I represent at this moment;
• that I will receive compensation such as commissions for the sale of life and accident and sickness insurance company products;
• that I may receive additional compensation in the form of bonuses, conference programs or other incentives; and
• that I have disclosed any conflict of interest that I may have with respect to this transaction.

I declare that I have a valid licence for the territory where this application has been signed.
I hereby declare that all information in this application is true and complete to the best of my knowledge.

Name of authorized representative / financial security advisor (please print)	X **Signature** of authorized representative / financial security advisor	D D M M Y Y Y Y Date

Application number _____

This notice must always be given to the client.

Section 22: Receipt

Any new application becomes effective on the date when it is accepted by Beneva Inc., provided that it is accepted without modification, that the initial premium has been paid and that there has been no change in the proposed insured's insurability between the date the application was signed and the effective date of the policy. Any benefit modification request or addition of benefit(s) request to the policy becomes effective on the day of the month of the policy following the date the request is accepted by Beneva Inc. on the condition that the modification request or the addition of benefit(s) request is accepted without change, that the premium has been paid and that there has been no change in the proposed insured's insurability between the date the modification request or the addition of benefit(s) request has been signed and the date the modification request or addition of benefit(s) came into force. Any benefit cancellation request becomes effective on the day of the month of the policy following the date the request is received by Beneva Inc.

Beneva Inc. does not take upon any obligation unless this request has been signed by the proposed insured, the policyowner and the authorized representative / financial security advisor, the initial premium has been paid, the eligibility requirements have been met and the application and corresponding medical questionnaire have been approved by Beneva Inc.

$ _____
Modal premium received

_____
Name of authorized representative / financial security advisor (please print)

_____
Code

X _____
Signature of authorized representative / financial security advisor

D D M M Y Y Y Y
Date