La Capitale
Financial Security

APPLICATION #

APPLICATION FOR ACCIDENT ONLY INSURANCE

☐ NEW APPLICATION or
☐ PLAN CHANGE / ☐ REINSTATEMENT / ☐ INCREASE TO POLICY N° _____

GENERAL INFORMATION

Language of correspondance: ☐ English ☐ French

Last name (Policyholder/insured)		First name		
Middle name	Last name at birth (if different)		S.I.N.	
Address (No., street)			Apt.	Postal code
City	Province	Age	Sex ☐ Male ☐ Female	Country of birth
Date of birth M M D D Y Y Y Y	Home tel.		Business tel.	Extension
Cell tel.	Best time to call _____ ☐ AM ☐ PM	Best tel. number to call ☐ Home ☐ Business ☐ Cell		Email address
Emergency contact name	Emergency contact tel.		Association: ☐ No ☐ Yes – If so, name of the association:	

Identification type (photo ID issued by a federal or provincial government): _____ Province or country of issue: _____

Document No.: _____ Jurisdiction of issue: _____ Expiry date (if available): M M Y Y

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

SECTION 1 – PRODUCT SELECTION I hereby apply for the Accident Only coverages I have selected below:

Policy/Rider Applied For:	Policy or Rider	Elim. Period	Benefit Amount	Policy or Rider Service Premiums[1]	Annual Premium Including Service Premiums
_____	☐ Policy ☐ Rider	_____	$_____	$_____	$_____
_____	☐ Policy ☐ Rider	_____	$_____	$_____	$_____
_____	☐ Policy ☐ Rider	_____	$_____	$_____	$_____
☐ ROP-PVR (Return of Premium Rider[2])				$_____	$_____
				Provincial Sales Tax (PST) if applicable	$_____
				TOTAL ANNUAL PAYMENT[3]	$_____

Note 1: Policy and Rider Service Premiums are charged on an annual basis.
Note 2: Policy Service Premiums, Rider Service Premiums and any fees charged with regard to a method of payment option will not be reimbursed.
Note 3: This amount includes the Policy and Rider Service Premiums and any applicable taxes (e.g., PST) and fees.

SECTION 2 – INCOME AND OCCUPATION

Part A (Self-Employed) Occupation and exact duties: _____

Type of business: ☐ Sole proprietor ☐ Partnership ☐ Corporation | If owner, percentage of ownership: ____ | Home based business? ☐ Yes ☐ No

Company name: _____ | Date business started: _____

Hours per week worked: _____ | Years in industry: _____ | Number of employees: _____

Have you filed for bankruptcy in the last 3 years? ☐ Yes ☐ No | If Yes, when was your bankruptcy discharged? Date: _____

What estimated percentage of work is: Labour ___ % Administrative ___ % Supervisory ___ % Client Relation/Marketing ___ % Actual Driving ___ %

If less than 12 months earned, indicate number of months earned – do not project earnings (last 2 years)	20 _____	20 _____
Gross annual Business income	_____	_____
Less all operating Expenses	– _____	– _____
Net earned annual income[4]	= _____	= _____

Part B (Employee) Occupation and exact duties: _____

Employer's name, address & phone number: _____

Hours per week worked: _____ Years employed: _____ **Gross earned annual income**[4]: $ _____

COMPLETED BY: ☐ SALES OFFICE ☐ AGENT/ADVISOR

The individual who wrote this application must be listed below as either Agent/Advisor 1, 2, 3 or 4 and provide his/her own agent code.

Sales/Regional Office/Mail Code: _____

Agent/advisor 1 name: _____	Agent/advisor code: _____	Share %: _____
Agent/advisor 2 name: _____	Agent/advisor code: _____	Share %: _____
Agent/advisor 3 name: _____	Agent/advisor code: _____	Share %: _____
Agent/advisor 4 name: _____	Agent/advisor code: _____	Share %: _____

Complete when partnership, business or family applications are being submitted together:
☐ Group with **Last name** _____ **First name** _____

Note 4: Investment income, dividends, rental, pension, employment insurance payments are not considered insurable income for purposes of calculating eligible insurance coverage amount.

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SECTION 3 – COMPLETE IN ALL CASES

Present Height: _____ ft. _____ in. **or** _____ cm **Present Weight:** _____ lbs. **or** _____ kg

	Yes	No
1. Are you currently receiving disability benefits, including but not limited to worker's compensation, due to an accident, injury, sickness or disability?	☐	☐
2. Within the last 3 years:		
a) have you lost more than 10 continuous days of work or been hospitalized as a result of sickness or injury?	☐	☐
b) have you received benefits from any source?	☐	☐
c) have you been charged with impaired driving under the Criminal Code, been charged with careless or dangerous driving, or had your driver's licence suspended?	☐	☐
d) have you been incarcerated?	☐	☐
e) have you had 3 or more moving violations?	☐	☐
3. In the last 3 years, have you had any indication or medical treatment or consulted a physician for alcohol/drug usage? *(If Yes, complete Alcohol/Drug, ZL-436 Usage Questionnaire.)*	☐	☐
4. Do you engage in competitive racing or speed contests (limited to vehicles)?	☐	☐
5. a) Are you now insured or are applications pending for Life, Accident or Sickness Insurance (including group or union coverages) or have you ever been insured by La Capitale Financial Security Insurance Company (formerly known as Penncorp Life Insurance Company)? *(If Yes, provide details in chart provided below.)*	☐	☐
b) Are you applying for any other coverage with La Capitale? *(If Yes, please provide details in chart provided below.)*	☐	☐
6. Do you have a valid driver's licence? *(If No, provide details.)*	☐	☐

Provide details for Question #5 in this chart.	Name of company	Year of Issue	Life Insurance Plan	Life Insurance Amt	Monthly Benefit	Accidental Death	Benefit Period Acc.	Benefit Period Sick.	Elimination Acc.	Elimination Sick.	Pending, Retaining or Replacing
											☐ PENDING ☐ RETAINING ☐ WILL IMMEDIATELY REPLACE UPON ACCEPTANCE OF THE INSURER

Skip SECTION 4 and proceed to complete the final steps of this application if applying for Accident Only Hospitalization, Safe Driver, Accidental Death, Convalescence or 6 month disability (accident only) less than or equal to $2,000/month total Insurer coverage.

SECTION 4 – ACCIDENT ONLY DISABILITY BENEFIT SECTION

Have you lost more than 4.5 kgs (10 lbs.) in the last year? Yes ☐ No ☐ If Yes, number of kgs (lbs.) lost and reason: _____

Name of physician: _____ Phone number: _____

Address: _____

Date of last consultation: _____ Reason: _____ Result: _____

	Yes	No
1. Within the last 10 years:		
a) have you received benefits from any source?	☐	☐
b) have you used or do you currently use narcotics, hallucinogens, barbiturates, amphetamines, marijuana, cocaine, heroin or other drugs except as prescribed by a physician? *(If Yes, complete Alcohol/Drug, ZL-436 Usage Questionnaire.)*	☐	☐
c) have you had any indication or medical treatment or consulted a physician for alcohol/drug usage? *(If Yes, complete Alcohol/Drug, ZL-436 Usage Questionnaire.)*	☐	☐
d) have you ever been treated for or advised for, or had any indication of:		
i. disorders of the spine, back, joints (including but not limited to dislocated joints), hips, back pain or sciatica? *(If Yes, complete Back Pain and Musculoskeletal, ZL-438 Questionnaire.)*	☐	☐
ii. arthritis, rheumatism, gout, neuritis, or disorders of the muscles or bones (included but not limited to sprains, tears and pulled muscles or broken bones), or have any deformity or amputation? *(If Yes, complete Back Pain and Musculoskeletal, ZL-438 Questionnaire.)*	☐	☐
iii. dizziness/fainting, epilepsy, paralysis, dementia, Alzheimer's, Parkinson's or organic brain disease?	☐	☐
iv. depression, schizophrenia, other mental or nervous disorder?	☐	☐
v. chronic pain or fatigue, fibromyalgia, Epstein-Barr syndrome or sleep apnea?	☐	☐
vi. diabetes, elevated sugar in blood or urine? *(If Yes, complete Diabetes, ZL-436B Questionnaire.)*	☐	☐
2. Within the last 3 years:		
a) have you engaged or intended to engage in any hazardous activities such as, but not limited to (a) rodeo, (b) mountain or rock climbing, (c) hang gliding, (d) parachuting, (e) competitive racing or speed contests (not limited to vehicles)? *(If Yes, complete Sport, Amusement, or Avocation, ZL-436A Questionnaire.)*	☐	☐
b) have you been advised to have any diagnostic test (other than any related to genetic testing) or surgery which has not been done yet, or has been completed but the results not received?	☐	☐
c) have you ever had a life, critical illness, long-term care or disability insurance application declined, deferred, modified or rated with a higher premium?	☐	☐
3. Have you ever been treated for, tested positive or been diagnosed as having an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or Aids-Related Complex (ARC) or tested positive for HIV?	☐	☐
4. Are you currently taking any prescribed medications? *(If Yes, provide details in the chart provided below, including list of medications and dosages.)*	☐	☐

If any questions in SECTION 3 or 4 have been answered "Yes", please provide details below.

Section number	Question number	Details or name of injury or sickness	Date started	Date recovered	Details of treatment and/or operation (dosage of medication)	Was recovery complete? If no, give details of remaining effects	Name and address of attending physician and/or hospital

AUTHORIZATION: I hereby authorize the Insurer or its reinsurers, for underwriting, administration and claims adjudication purposes only: a) to gather only that information necessary from any person or organization that has personal information relating to me or any family member to be insured, including other insurers, physicians, medical institutions, provincial or territorial WCB, WSIB or WHSCC, other government organizations, the MIB, Inc., investigation and consumer reporting agencies, and all persons likely to have personal information relevant to the object of the file; b) to disclose to these same persons and organizations only the necessary personal information relating to me to allow them to collect the required information; c) to share such information as is necessary for the purposes described above with the advisor and agency of record of the policy issued in connection with this application; and d) to make a brief report of my personal health information to MIB, Inc. I understand and agree that: a) the Insurer may provide access to my personal information to service providers located in jurisdictions outside Canada who provide the Insurer with, without limiting, information technology, data storage, claims adjudication and reinsurance services; and b) I can obtain access to the Insurer's policy on personal information protection at www.lacapitaleFS.com under "Privacy Policy". A photocopy of this authorization is as valid as the original. This authorization is valid for the period required to achieve the purpose for which it was requested. I acknowledge receipt of notice regarding the MIB, Inc. I acknowledge that the Insurer may refuse to consider my application for insurance if I do not comply completely with this authorization.

Date: M M D D Y Y Y Y **Signature of policyholder/insured:** X_____

DO NOT DETACH THIS AUTHORIZATION – RETURN TO HEAD OFFICE

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SECTION 5 – BENEFICIARY DESIGNATION

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

	Last name	First name	Date of birth (MM/DD/YYYY)	Relation to policyholder/insured	Select designation Revocable	Irrevocable
Primary					☐	☐
Contingent					☐	☐

SECTION 6 – DECLARATION & AGENT/ADVISOR STATEMENT

DECLARATION – I hereby apply to La Capitale Financial Security Insurance Company (the Insurer) for an insurance policy to be issued in reliance upon the written answers to the questions in this application. I agree that the answers recorded on this application are my own and are true and complete. I agree and understand that the application is not be binding upon the Insurer until approved by the Insurer.

Dated at: City _____ **Province** _____ **on** _____
Month Day Year

Signature of policyholder/insured: X _____

AGENT/ADVISOR STATEMENT

If Delivery Has No Requirements: ☐ MAIL POLICY TO POLICYHOLDER/INSURED ☐ MAIL POLICY TO OFFICE

I hereby certify that I have truly and accurately recorded on this application the information supplied by the policyholder/insured. I certify that I have disclosed the names of the companies 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 disclosing as any potential conflicts of interest with regard to this sale. I certify that I have seen the client in person and that I have seen the client's identification and compared the signature on the identification document with the policyholder/insured's signature on the application.

	Yes	No
Can the policyholder/insured read, speak and understand ☐ **English** or ☐ **French**?	☐	☐
If "NO" have you fully explained the details of the application to the policyholder/insured and are you satisfied that the application is fully understood?	☐	☐
Do you have any knowledge of the policyholder/insured personal habits, health, avocations, finances or reputation that might affect the underwriting risk?	☐	☐
I have given the policyholder/insured the MIB, Inc. Notice and Client Information Notice	☐	☐

_____ **Signature of Licensed Agent/Advisor**

_____ **Signature of Training Supervisor** (If required under provincial legislation)

CONDITIONAL RECEIPT

APPLICATION NO. _____ **PLAN SELECTED** _____

If you qualify, policy/rider may take up to six weeks to issue. If acknowledgement is not received within 30 days, contact us at (refer to application #):
LA CAPITALE FINANCIAL SECURITY INSURANCE COMPANY 1 800 268-2835 (English) or 1 800 363-8011 (French)

RECEIVED FROM _____ **Date** _____**. This receipt is issued for $**_____
for an application for the insurance described in the policy/rider applied for. If all the following conditions are met and the Insurer issues a policy/rider as applicable to the policyholder/insured, such policy/rider will cover the policyholder/insured in accordance with its provisions, limitations and exceptions, for losses on or after the date of application:

1. All the information given by the policyholder/insured in the insurance application or any supplementary form must be accurate and complete.
2. The Insurer must find the policyholder/insured qualified for the plan and amount applied for in accordance with its normal and customary underwriting standards and practices.
3. The payment for which this receipt is issued must be one complete payment, according to the Insurer's underwriting rules, for the payment method selected in the application.

IN THE EVENT THE APPLICATION IS REJECTED, THE ABOVE AMOUNT WILL BE REFUNDED IN FULL BY THE INSURER.

TOTAL ANNUAL PAYMENT $_____ **Licensed Advisor** _____

Cheque or money order payable to La Capitale Financial Security Insurance Company must accompany the application or Authorization for the Initial Payment by Credit Card must be duly completed and signed.

THIS NOTIFICATION MUST BE DETACHED AND DELIVERED TO THE POLICYHOLDER/INSURED

MIB, Inc. Notice on REVERSE →

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SECTION 7 – PAYMENT

PAYMENT METHOD SELECTION: ☐ Preauthorized Debit (PAD) Complete Section 8. ☐ Semi-annual ☐ Annual

SELECT METHOD FOR THE INITIAL PAYMENT

☐ Cheque or money order attached to this application $ _____ Must be made out to La Capitale Financial Security Insurance Company.

☐ Credit card Complete Section 9.

SECTION 8 – PREAUTHORIZED DEBIT (PAD) AGREEMENT

PREMIUM PAYOR'S INFORMATION

☐ Policyholder or insured ☐ Other: ☐ Mr. ☐ Ms. _____ First name _____ Last name

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

_____ Area code _____ Tel. Date of birth: _____ Year _____ Month _____ Day

☐ Business: _____ Company name _____ Area code _____ 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

_____ 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. 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.

SIGN HERE _____ Signature of premium payor or authorized signatory _____ 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

SECTION 9 – INITIAL PAYMENT BY CREDIT CARD

PART A – NOTICE

Part B below, which only contains information regarding the credit card used as the initial payment method, will be voluntarily deleted from this document prior to being filed in the Insurer's records. This is done for purposes of confidentiality and compliance with applicable laws and rules. The deletion of Part B does not constitute an alteration of this document of any kind whatsoever. The parties therefore agree that despite the deletion of Part B, this document represents the entire and complete agreement between the parties with respect to its subject matter.

PART B – AUTHORIZATION FOR THE INITIAL PAYMENT BY CREDIT CARD

Authorization No. Reserved for the Administration

☐ Visa ☐ MasterCard ☐ American Express

Credit card number: _____ _____ _____ _____ Expiry date: M M Y Y

I authorize the Insurer to charge the initial payment of $ _____ to the above-mentioned credit card. Upon receipt of this authorization, the Insurer will request the necessary authorization from the credit card issuer. If such authorization is obtained from the credit card issuer, the credit card will be charged. In the event the premium is increased after my application is reviewed, I authorize the Insurer to charge the additional amount to the credit card. In the event the initial premium is decreased, the Insurer will reimburse any excess by cheque.

SIGN HERE _____ Credit cardholder's signature _____ Credit cardholder's name _____ Date

CLIENT INFORMATION NOTICE

YOUR TEN-DAY (10) RIGHT TO EXAMINE YOUR POLICY/RIDER

(a) It is our wish that you fully understand and be satisfied with this policy/rider. If you are not satisfied with this coverage, return it to us or our agent within ten (10) days after you receive it. If you do so, this policy/rider will be deemed void from the start. Any premium paid for it will then be fully refunded.

REVIEW YOUR APPLICATION

(b) You have signed a declaration on the application that the answers recorded on this application are your own and are true and complete. A copy of your application is enclosed in your policy. If your answers are incorrect or untrue, the Insurer may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises.

MIB, INC. NOTICE DATE _____ NAME OF POLICYHOLDER/INSURED _____

Information regarding your insurability will be treated as confidential. The Insurer or its reinsurers, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 416 597-0590. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction. The address of MIB, Inc.'s information office is 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7. The Insurer, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com. MIB, Inc. receives personal information and the collection, use and disclosure of such information is governed by the Personal Information Protection and Electronic Documents Act ("PIPEDA") and provincial laws. Therefore, MIB, Inc. has agreed to protect such information in a manner that is substantially similar to the Company's privacy and security practices, and in accordance with applicable laws. As a U.S. based company, MIB, Inc. is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. If you have any questions about MIB, Inc.'s commitment to protect the confidentiality and security of your personal information, you may contact the MIB, Inc. Privacy Department at privacy@mib.com.

NOTICE CONCERNING THE PROTECTION OF PERSONAL INFORMATION At La Capitale, we respect your privacy, because we know how important it is to keep your personal information confidential and secure. That is why we have adopted a Personal Information Protection Policy and implemented safeguards to protect your personal information. We collect and use your personal information to manage your Insurance, Annuity, and Credit Financial Services or Related Services insurance file. Your personal information is stored at our offices and protected by high security measures in accordance with the laws and regulations applicable to the protection of personal information. Only our employees, mandataries, distribution partners (such as agents and their firms) and service providers may access your personal information, and solely when such access is required to perform their duties, carry out their mandate or fulfil their service contract. La Capitale may do business with one or more service providers based outside of Canada. It is therefore possible that some of your personal information held by La Capitale may be stored outside of Canada and governed by the laws of foreign countries or states. If you would like to access your file or make a correction to it, make your request in writing to the following address: La Capitale Financial Security Insurance Company, 7150 Derrycrest Drive, Mississauga ON L5W 0E5. La Capitale Financial Group Inc., its subsidiaries and their authorized representatives may use your personal information to inform you of products and services that may be of interest to you, as part of their customer service initiatives. If, however, you do not wish to receive this type of information, please write to us at the address above. For more information about our personal information protection practices, refer to our personal information protection statement at www.lacapitalefs.com/en/personal-information-protection.