NATIONAL BANK INSURANCE

Insurance application

TERM LIFE INSURANCE PLAN

10-YEAR TERM LIFE INSURANCE PLAN – renewable every 5 years

INSURANCE AMOUNT CHOSEN

_________________________ $ Amount must be from $100,000 to $5,000,0000

PERSONAL INFORMATION (TO BE ELIGIBLE, YOU MUST BE BETWEEN AGE 20 AND 64 AND A RESIDENT OF CANADA)

Name ______________________ First name ______________________

Address ______________________ City ______________________

Province ____________ Postal Code ____________ Gender ☐ *Male* ☐ *Female* Date of birth Y Y Y Y | M M | D D

Place of birth *(Country, City)* ______________________ Social Insurance No ______________________

Occupation ______________________ Height ____________ Weight ____________ *lb* ____________ *kg*

IMPORTANT NOTICE

If you are purchasing this policy to replace a policy you currently hold, we recommand that you do not cancel your current policy until we have sent you your contract. Please also note that the clauses pertaining to suicide and incontestability shall apply for a period of two years commencing on the effective date of your new policy.

DURING THE PAST 12 MONTHS

Have you used any type of tobacco product? ☐ YES ☐ NO

DURING THE PAST 3 YEARS

1. Did you suffer from or have been diagnosed with AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immune Deficiency Virus) or any other immune sickness or disorder, or have you visited or were you treated, had a medical examination, a medical follow-up or a medical treatment for these conditions? ☐ YES ☐ NO

2. Have you ever used drugs without a medical prescription or have you ever had treatment or joined an organization due to alcohol use, or has a medical practitioner advised you to reduce your alcohol use? ☐ YES ☐ NO

3. Did you ever submit a life insurance application which was rated, declined or restricted? ☐ YES ☐ NO

4. Do you play a dangerous sport (such as scuba diving, flying, parachute diving, etc.)? ☐ YES ☐ NO

WE WILL CONTACT YOU

The Insurer may request, if necessary, that a physical examination, electrocardiogram, X-rays, blood tests, urine tests or any others, including the test to detect HIV (AIDS) and certain drugs or medication be conducted.

To make a decision, the Insurer or a paramedical firm will contact you.

WHEN WILL BE THE BEST TIME TO CONTACT YOU:

☐ Day (   ) ________________ Ext.______ ☐ Night (   ) ________________ Ext.______

STATEMENTS AND AUTHORIZATIONS

I certify that all information provided in this application is true, and I agree that such information shall form part of the policy.

I understand that the policy will be issued on the basis of the rates determined in accordance with my smoking habits.

I also understand that any omission or any misrepresentation will automatically cause my insurance to be cancelled.

I agree that the coverage will only become effective on the date on which the Insurer approves my application, provided that the first premium has been paid and that no change has occurred in my health since the date on which the application was signed.

I acknowledge having read the notice "Medical Information Bureau" and "Access to Personal Information" on page 2 of this application.

I authorize the Insurer to include my name, address and telephone number in his list of clients for business or charitable prospecting by the Insurer or any person to whom he agrees to release this list, and I reserve the right to terminate this authorization at any time by a verbal or written request to the Insurer.

I undertake to inform you immediately, in writing, of any change to my name, address and telephone number so that you can update your files.

I agree to be bound by all the provisions of the insurance policy and **I authorize** the Insurer and National Bank of Canada to use my Social insurance Number for administrative purposes.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Insurer or its reinsurers, any such information.

I authorize the Insurer to use all the information that are held on my accounts, including those coming from closed files. This authorization shall be valid for the duration necessary for achieving the purposes for which it was requested. A copy of this authorization shall be as valid as the original.

I hereby authorize the Insurer to deduct from my account indicated on page 2, each month, all amounts required for the insurance premium under this application.

NATIONAL BANK INSURANCE

STATEMENTS AND AUTHORIZATIONS *(continued – please complete and sign)*

PRE-AUTHORIZED DEBIT APPLICATION - PAYOR'S PERSONAL PAD AGREEMENT ☑ **PERSONAL** ☐ **BUSINESS**

Withdrawal authorization (frequency and amount of debits): I, the undersigned, authorize the Insurer, its successors, potential transferees or assigns, to carry out, effective immediately, personal pre-authorized debits (PADs) on my account held at the financial institution designated below, on a monthly basis starting with the payment of the initial premium. The date of payment of the initial premium will be indicated in the Summary of Coverage which I will receive when the insurance policy is mailed, subject to approval of my application by the Insurer. Each withdrawal corresponds to a fixed amount which can be modified, in particular should the withdrawal of the initial premium not be accepted, provided the Insurer sends me a written notice at least 10 days before the deadline of the modified withdrawal.

Waiver: I waive any other confirmation before the first payment and I waive my right to receive notification should the amount of the withdrawal change.

Change or cancellation: I agree to notify the Insurer, at least five days before the next scheduled withdrawal, of any changes to the bank account information or to the date of payment. **I also authorize** the Insurer to make withdrawals on another account, following my verbal or written instructions. In the case of a joint account, the expression "I" used in this agreement refers to all signatories.

This authorization remains in effect until the Insurer receives notification of any changes or cancellation by me. **I may revoke** my authorization at any time, subject to providing 30 days notice. I may obtain a sample cancellation form, or further information on my right to cancel a PAD Agreement, at my financial institution or by visiting the Canadian Payments Association website at www.cdnpay.ca. **I release** the Institution from any liability if the revocation is not respected, except in the case of gross negligence on its part.

Reimbursement: I have certain recourse rights if a 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 Personal PAD Agreement. For more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Consent to the disclosure of information: I agree and understand that the information contained in my pre-authorized debit application will be disclosed to the financial institution, to the extent that such disclosure is directly related to and necessary for the proper application of regulations related to pre-authorized debits.

PAYMENT AUTHORIZATION AND INFORMATION ABOUT THE ACCOUNT

☐ **PRE-AUTHORIZED CHEQUING**

Name of the Financial Institution where the account is held

Institution No. Transit

Account No.

Branch address

Important: Attach a personal cheque marked "VOID" to avoid any transcription errors.

☐ **NATIONAL BANK MASTERCARD ACCOUNT**

5258

Card No.

M M | A A

Expiry date

PAYEE

National Bank Life Insurance Company

1100 University, 5th Floor, Montreal, Quebec, H3B 2G7
Telephone: 1 877 871-7500 Fax: 514-396-6604

SIGNATURE

X ____________________ Date ____________________

Client's Signature

Notice concerning the Medical Information Bureau

The information on your insurability will be strictly confidential. However, National Bank Life Insurance Company or his reinsurer may release a summary of this information to the Medical Information Bureau, a non-profit organization, providing an exclusive service to life insurance companies, which maintains a data centre for its company members. If you submit a life or health insurance application or a claim to one of the member companies, the Bureau will provide them, if requested, the information contained in its files. The Bureau will provide, on request, all information it holds on you. If you question the Bureau's information, you may request that it be corrected by contacting the Medical Information Bureau, 330 University, Suite 501, Toronto, Ontario, M5G 1R7. Telephone: 416-597-0590. The Insurer may also release the information that he has to another insurance company to whom you submitted a life or health application or a claim.

Access to personal information

In order to protect the confidentiality of the personal information that is held on you, National Bank Life Insurance Company shall establish an insurance file in which the information regarding your application for insurance and any claim will be included. Only those employees or agents who are responsible for underwriting, administration, investigation and claims, or any other person authorized by you, will have access to this file. Your file will be held in the Insurer's office. You will be entitled to have access to the personal information contained in your file, and if appropriate, have it corrected by sending a written request to: National Bank Life Insurance Company, Personal Information Officer, 1100 University, 5th Floor, Montreal, Quebec H3B 2G7.

Exclusions

If, within two (2) years of the *Effective Date* or reinstatement of the *Contract*, the *Insured* commits suicide or dies directly or indirectly as a result of an intentionally self-inflicted injury, while of sound mind or not, the *Insurer's* obligation shall be limited to refunding the premiums paid under this *Contract* since the *Effective Date* or reinstatement date, as applicable.

Questions?

Call 1-877-871-7500 (toll-free)

A Customer Service Representative will be pleased to assist you.

Mail both pages of the completed enrollment form to:

National Bank Life Insurance Company
1100 University, 5th Floor
Montreal, Quebec H3B 2G7

(Rev. 02/2010)

Insurer: National Bank Life Insurance Company.
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