NATIONAL BANK
INSURANCE Life | Health

INSURANCE APPLICATION
CRITICAL ILLNESS INSURANCE

Part I
Information on the insured

INFORMATION ON THE INSURED

First name ____________________ Last name ____________________

Date of birth (YYYY MM DD) ____________ Sex ____________

Address ____________________

City ____________ Province ____________ Country ____________ Postal code ____________

Telephone ____________ Email ____________

Insurance amount requested ($25,000 OR $50,000): ____________________

If you already have a Critical Illness Insurance policy with National Bank Life Insurance Company (excluding loan insurance and 10 or 20 years term life insurance coverage), the total amount of all policies may not exceed $50,000. Your coverage will take effect when we confirm your acceptance.

ELIGIBILITY OF THE INSURED

1. Are you a Canadian citizen or permanent resident of Canada, and are you a Canadian resident for income tax purposes? ☐ Yes ☐ No
2. Do you already have a Critical Illness Insurance policy from National Bank Life Insurance Company (excluding loan insurance and 10 or 20 years term life insurance coverage)? ☐ Yes ☐ No
3. Is this insurance policy intended to replace another critical illness insurance policy currently in effect? ☐ Yes ☐ No

Renseignements généraux

1. I understand the designated language and I request that my policy contract, including this application, be concluded in this language. / *Je maitrise la langue indiquée et je demande que le libellé de ma police, y compris la présente proposition, soit établi dans celle-cie.* ☐ French *Français* ☐ English *Anglais*

Important Notice

If this policy is intended to replace another policy you currently hold, do not cancel your current policy until you have completed the replacement notice with a representative and that your contract is issued.

To schedule an appointment with a representative, contact us at ______________________.

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Declarations and authorizations

I agree to be bound by all provisions of the insurance policy.

I confirm it is my wish that this insurance application and the insurance policy as well as all related documents be drawn up in English. Je **confirme ma volonté** que cette demande d'assurance et la police d'assurance ainsi que tous les documents s'y rattachant soient rédigés en anglais.

(Quebec only – as of June 1st, 2023) The French version of this insurance application and the insurance policy is available here: assurances-bnc.ca/documentation.html, under Term life insurance, Accidental Death and Critical Illness section. I confirm having received this version. (Québec seulement – à partir du 1er juin 2023) La version française de cette demande d'assurance et de la police d'assurance est disponible ici : assurances-bnc.ca/documentation.html sous la section Assurance vie temporaire, maladie grave et décès accidentel. Je confirme avoir reçu cette version

I understand that, to determine my eligibility for insurance, process my insurance application, conduct the necessary investigations and, as needed, administer my file and process any claims, the *Insurer* and its reinsurers must be able to collect, use and disclose my personal information, including information on my health status.
To that end:

1. **I authorize** the *Insurer* and its reinsurers to collect the necessary information on me and my health status from any physician, hospital, clinic or insurance company, as well as from MIB LLC. (MIB) and any other organization or institution having such information.
2. **I authorize** the *Insurer* to use any necessary information it has on my account, including information from previous files.
3. **I authorize** the *Insurer* or its reinsurers to communicate any information on my health status or other relevant information about me to the MIB.

Notice about the MIB LLC.
Information regarding your insurability will be treated as confidential. The Insurer or its reinsurer may, however, make a brief report thereon to the MIB LLC, a not-for profit membership organization of the life insurance companies which operates an information exchange on behalf of its members. Upon request by a member insurance company to which you have applied for life or health insurance coverage, or to which a claim is submitted, the MIB LLC. will supply such company with the information on its file. Upon receipt of a request from you, the MIB LLC. will arrange disclosure of any information it may have on file. If you question the accuracy of the information in the MIB's file, you may contact the MIB LLC. and seek correction. Address ________________________________

The Insurer may also release information from its files to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com

Access to personal information
The *Insurer* will establish an insurance file in which all information concerning your insurance application and any claims made thereunder is included. Your file will be kept in the *Insurer*'s offices. You will be entitled to have access to the personal information contained in your file and, if applicable, have it corrected. For more information, consult the confidentiality policy of the *Insurer*, which is available online at www.__________________________________.

I declare that all information provided to the *Insurer* and its reinsurers is accurate. **I agree** to notify the *Insurer* as quickly as possible of any change in my personal information, so that my records may be kept up to date. **I acknowledge** having read and accepted the above conditions relating to the collection, use and disclosure of my personal information, including the "Notice about the MIB LLC" and "Access to personal information" sections.
This consent will be valid as of today and for the duration of my business relationship with the *Insurer* or for a longer period if permitted or required by law or as set out herein.

Do you authorize the *Insurer* to use the personal information it has on you to suggest products that may be of interest:

1. By sending you mailings or by calling any number you have provided?	☐ Yes	☐ No
2. By Email?	☐ Yes	☐ No

You can withdraw this consent at any time by contacting the *Insurer* at

____
____
____

____

____
Insurance contract No.
(reserved for insurer)

On ____

By ____

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Part II
Health status and medical history of the insured

HEALTH STATUS AND MEDICAL HISTORY OF THE INSURED

In order for your application to be eligible, you must complete this questionnaire.
If you already have a Critical Illness Insurance policy with National Bank Life Insurance Company (excluding loan insurance and 10 or 20 years term life insurance coverage), the total amount of all policies may not exceed $50,000.

1. Do you agree to answer all of these questions truthfully? ☐ Yes ☐ No
2. Have you ever applied for life or critical illness insurance and been declined, or been offered a policy with a higher premium or with limitations, or had a policy cancelled after issue by the insurer? ☐ Yes ☐ No
3. Please describe your smoking habits during the **last 12 months**. How often have you used cigarettes or other forms of tobacco, nicotine, nicotine substitute products, e-cigarettes and/or vaping? ______________________
4. Has a member of your immediate family (father, mother, brother or sister) suffered from diabetes, cancer, a stroke or heart disease before the age of 60? ☐ Yes ☐ No
5. What is your height? ________________ feet ________ inch ________ cm
6. What is your weight? __________ lb ________ kg
7. What is your weekly alcohol consumption? ______________________
(*1 consumption = 1 bottle of beer (341ml or 12onces); 1 glass of wine (150ml or 5onces); 1 liquor* (*43ml or 1.5onces*))
8. What is your marijuana consumption? ______________________
9. Have you ever consulted for or presented symptoms of or were ever told that you have any of the following:
   a. Cardiovascular disease, cardiac surgery, heart attack, chest pain, angina, arrhythmia or heart defect? ☐ Yes ☐ No
   b. Stroke, transient ischemic attack (TIA) or peripheral vascular disease? ☐ Yes ☐ No
   c. High blood pressure (hypertension) or high cholesterol (hyperlipidemia, dyslipidemia)? ☐ Yes ☐ No
   d. Diabetes (other than a history of gestational diabetes fully resolved), glucose intolerance or pre-diabetes? ☐ Yes ☐ No
   e. Cancer, malignant tumor, leukemia, lymphoma, melanoma, brain tumor, abnormal skin nodules or lesions? ☐ Yes ☐ No
   f. Blood disorder, anemia, hemochromatosis, coagulation disorder? ☐ Yes ☐ No
   g. Lung or respiratory disorder, sleep apnea or pulmonary embolism? ☐ Yes ☐ No
   h. Cystic fibrosis, chronic obstructive pulmonary disease (copd), chronic bronchitis or emphysema? ☐ Yes ☐ No
   i. Pancreas disorder (including pancreatitis) or colon polyps? ☐ Yes ☐ No
   j. Crohn's disease or ulcerative colitis? ☐ Yes ☐ No
   k. Liver disorder, biliary tract disorder (other than gallstones), hepatitis B, hepatitis C, cirrhosis or sclerosing cholangitis? ☐ Yes ☐ No
   l. AIDS or positive HIV test results? ☐ Yes ☐ No
   m. Kidney disorder or chronic kidney disease (other than kidney stones)? ☐ Yes ☐ No
   n. Breast or prostate disease or disorder? ☐ Yes ☐ No
   o. Neurological disorder, immune system disorder including lupus, rheumatoid arthritis or connective tissue disease? ☐ Yes ☐ No
10. In the last 10 years, have you:
   a. Been admitted to a rehabilitation or detoxification center, joined a rehabilitation program or received treatment or counselling for your alcohol or drug consumption? ☐ Yes ☐ No
   b. Used cocaine, heroin, or any drug not prescribed to you by a physician (other than marijuana and over the counter medication)? ☐ Yes ☐ No

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c. Had criminal charges brought against you, or do you currently have charges pending?	☐ Yes	☐ No
11. In the past 12 months, did you receive disability benefits for more than four consecutive weeks?	☐ Yes	☐ No
12. In the past 5 years, were you advised of abnormal results for any of the following tests:		
a. Electrocardiogram (EKG)	☐ Yes	☐ No
b. Echocardiogram (heart ultrasound)	☐ Yes	☐ No
c. Biopsy	☐ Yes	☐ No
d. MRI (Magnetic Resonance Imaging, other than for joints, muscles or bones)	☐ Yes	☐ No
e. Scan (CT or CAT scan)	☐ Yes	☐ No
f. Mammogram	☐ Yes	☐ No
g. Breast ultrasound	☐ Yes	☐ No
h. Colonoscopy	☐ Yes	☐ No
i. Pap test (Pap smear, cytology)	☐ Yes	☐ No
j. PSA test (prostate-specific antigen)	☐ Yes	☐ No
13. Other than routine exams, such as an eye exam, an allergy test, a blood test, an audiogram or a pregnancy test, have you been advised by a health care professional to have any clinical tests, treatments, or surgery that has not yet been completed, or are you awaiting the result of any clinical test, or an appointment with a specialist?	☐ Yes	☐ No
14. Do you have any symptoms for which you have not yet consulted a physician? This would include symptoms that are unexplained and have no known cause such as bleeding or pain, weight loss, lump or growth, dizziness or moles/freckles that have changed in size, bled or become painful. This does not include; colds, flus, earaches, eczema, appendicitis, gallstones or allergies.	☐ Yes	☐ No
15. Were you able to answer all questions on your own, without assistance or the help of a translator?	☐ Yes	☐ No

I declare that all the information provided concerning my medical history and health status is accurate.

Inaccurate information could void your insurance policy and cause your claims to be rejected.

____
Insurance contract No.
(reserved for insurer)

____

On ____

By ____

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