NATIONAL BANK INSURANCE

Hospitalization Plus Insurance
Application form

Hospitalization Plus Insurance

✓Yes! Please enrol me and the eligible members of my family (depending on the plan chosen) in the *Hospitalization Plus Insurance* plan.

1. PERSONAL INFORMATION

Choose the plan the best suits your needs and budget.
Tick only one box.

❍ **Individual plan**
To be eligible for the individual plan, you must be between ages18 and 69 and a Canadian resident at the time of enrolment.

❍ **Spousal plan**
To be eligible for the spousal plan, you and your spouse must be between ages 18 and 69 and Canadian residents at the time of enrolment.

❍ **Family plan without spouse**
To be eligible for the family plan without spouse, you must be between ages 18 and 69 and a Canadian resident at the time of enrolment, and your dependent children must be under age 18, or under age 24 if they are full-time students.

❍ **Family plan**
To be eligible for the family plan, you and your spouse must be between ages 18 and 69 and Canadian residents at the time of enrolment, and your dependent children must be under age 18, or under age 24 if they are full-time students.

Premium table

	Monthly premium			
Age	Individual plan	Spousal plan	Family plan without spouse	Family plan
18 - 44	$14.95	$28.40	$18.75	$32.20
45 - 54	$26.50	$50.35	$30.30	$54.15
55 - 64	$34.00	$64.50	$40.20	$70.70
65 - 69	$39.00	$74.00	$45.20	$80.20

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ PROVINCE _____ POSTAL CODE _____

E-MAIL ADDRESS _____ TELEPHONE NO. (HOME) _____ TELEPHONE NO. (WORK OR CELL) _____

SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH: DD / MM / YYYY

2. DECLARATIONS AND AUTHORIZATIONS

I **certify** that all the information provided on this Application Form is true and **acknowledge** that this information is part of the policy.

I **understand** that any omission or false declaration may cause my insurance to be cancelled automatically.

I **understand** that my coverage becomes effective the day the Insurer receives my duly completed Application Form.

I **acknowledge** that I have read and understood the Exclusions from insurance coverage on page 2 of this Application Form.

I **acknowledge** having read the notice "Access to personal information" on page 2 of this Application Form.

I **understand** that my policy contract, confirming the coverage I have selected, will be sent to me shortly.

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

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

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

COMPLETE PAGES 1 AND 2

2. DECLARATIONS AND AUTHORIZATIONS (CONTINUED)

Pre-authorized Debit Application - Payor's 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 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. 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 financial 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	☐ NATIONAL BANK MASTERCARD ACCOUNT
Name of the Financial Institution where the account is held	5258 ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Card No.
Institution No. ☐☐☐ Transit No. ☐☐☐☐☐ Account No. ☐☐☐☐☐☐☐☐☐☐☐☐	
(Branch address)	☐☐/☐☐ Expiry date
Important: Attach a personal cheque marked "VOID" to avoid any transcription errors.	
Payee: National Bank Life Insurance Company 1100 Robert-Bourassa Blvd, 5th Floor, Montreal, Quebec, H3B 2G7 Telephone: 1-877-6604 Fax: 514-394-6604	

SIGNATURE MANDATORY

_____ _____

Signature Date

3. EXCLUSIONS

No daily hospital or recovery benefit is paid if the hospitalization was caused, directly or indirectly, by one or more of the following:

- **Self-inflicted harm** – attempted suicide, self-inflicted injury while sane or insane
- **War or insurrection** – declared or undeclared war, any act of war, riot or insurrection, or service in the armed forces of any country or international organization
- **Drugs or poison** – voluntary ingestion of poison, toxic or non-toxic substances, or drugs, sedatives or narcotics unless taken or used as prescribed by a Physician, or voluntary inhalation of a gas
- **Drug or alcohol addiction** – treatment for drug addiction, drug abuse, or alcoholism
- **Criminal offence** – committing or attempting to commit a criminal offence, or committing or inciting assault
- **High-risk activity** – including but not limited to motor vehicle racing, scuba diving, skydiving, parachuting, hang-gliding, rock or mountain climbing, bungee jumping, or flight accidents except as a passenger on a commercially licensed aircraft
- **Cosmetic surgery** – cosmetic treatment or cosmetic surgery, except when necessary due to a Covered Injury
- **Pre-existing condition or illness** – this provision refers to health problems the Covered Person had prior to the Insurance Effective Date. The Covered Person may therefore have to wait twelve (12) months before obtaining coverage if Hospitalization results from a Covered Illness or Covered Injury or symptom for which the Covered Person was treated during the twelve (12) month period immediately preceding the Insurance Effective Date.
- **Mental or nervous disorder** – neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional illness or disorder of any kind
- **Pregnancy** – Direct or indirect effects of pregnancy, whether or not there were attendant medical complications
- **Childbirth** – If the Covered Person is a Dependent Child who dies no more than fourteen (14) days after birth

ACCESS TO PERSONAL INFORMATION

In order to protect the confidentiality of the personal information that is held on you, the Insurer 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, including the reinsurer, or any other person authorized by you, will have access to this file. Your file will be held by the Insurer or one of its agents. You will be entitled to have access to the personal information contained in your file and, if applicable, have it corrected by sending a written request to: National Bank Life Insurance Company, Access to Personal Information Officer, 1100 Robert-Bourassa Blvd, 5th Floor, Montreal, Quebec, H3B 2G7.

Questions?
Please call us toll-free at 1-877-871-7500.
A customer service representative
will be pleased to assist you.

Please mail both pages of your Application Form to:
National Bank Life Insurance Company
1100 Robert-Bourassa Blvd, 5th Floor
Montreal, Quebec H3B 2G7

(Rev01/2016)

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