NATIONAL BANK INSURANCE

1100 Robert-Bourassa Blvd, 5th Floor, Montreal, Quebec H3B 2G7

COMMERCIAL LOAN INSURANCE APPLICATION

Commercial Term Loan – Commercial Mortgage Loan
Life, critical illness and accidental dismemberment, disability
Police No. 70009-17 (2017-11-01)

LOAN INFORMATION

☐ Term Loan ☐ Mortgage Loan

Loan No. _____ Loan transit _____

$ _____ _____ _____

Loan amount as at application date | Disbursement/Approval date (YYYY MM DD) | Amortization period (in months)

☐ New application ☐ Adding an insured ☐ Adding a protection

Is this a refinancing? ☐ Yes Previous loan No.: _____ ☐ No

If your insurance application is refused, the insured balanced of your previous loan will be maintained, subject to the terms and conditions of the certificate enclosed with this application (see the *Refinancing* section of the certificate).

IDENTIFICATION

Company name _____ Company – CIS No. _____

Applicant

CIS No. _____ Date of birth (YYYY MM DD) _____ Sex: ☐ M ☐ F

Name _____ First name _____ E-mail _____

ELIGIBILITY

To be eligible for insurance, you must, at the time you sign the application:

Life insurance

- Be between 18 and 64 years old **and**
- Be a resident of Canada or the United States **and**
- Be a borrower, co-borrower, guarantor, endorser, shareholder, officer or key-person of one of the borrowing company.

Critical illness and accidental dismemberment insurance

- Have signed up for life insurance.

Disability insurance

- Have signed up for life insurance **and**
- In the past 4 weeks, have completed at least 60 hours of remunerated work, or, if you are self-employed, have generated a gross income of at least $10,000 during the fiscal year prior to signing the application.
- If you are receiving income replacement benefits or if you are on a leave of absence or unemployed, **you are not eligible for disability insurance.**

Present employer's name _____ Employed since (YYYY MM DD) _____

APPLICATION – WAIVER - INELIGIBILITY

Life insurance	Critical illness and accidental dismemberment insurance	Disability insurance
☐ **I request** Insured amount chosen ☐ Authorized amount of loan (maximum life insurance amount = $2,000,000) or ☐ Select an amount $ _____ (may not exceed the loan authorized amount or maximum life insurance amount of $2,000,000) If not completed, loan authorized amount will apply	☐ **I request** Insured amount chosen $ _____ (may not exceed $150,000 or the insured amount indicated for life insurance) If not completed, the insured amount for life insurance will apply	☐ **I request** Insured amount chosen ☐ Loan payment $ _____ (may not exceed the maximum amount for disability insurance of $5,000/month) or ☐ Select an amount $ _____ (may not exceed the loan payment or the maximum for disability insurance of $5,000/month) If not completed, the loan payment will apply
☐ **I waive or I am not eligible**	☐ **I waive or I am not eligible**	☐ **I waive or I am not eligible**

Date (YYYY MM DD) _____ **X** _____

Applicant signature

ATTESTATION

I certify that eligible persons were given the opportunity to obtain insurance on the above loan.

X _____ _____

Signature of a person from the company authorized to take out the loan | Date (YYYY MM DD)

SMOKING STATUS

During the last 12 months, have you used tobacco or used nicotine replacement products in any form?

Yes	No
☐	☐

No representative of National Bank of Canada nor any other person may amend the provisions of this insurance application or the Certificate of Insurance.
All amended or incomplete forms shall be considered null and void.

HEALTH DECLARATION

Applicant CIS No.: _____

Instructions:

- You are insured without having to complete the Health Declaration, **subject to the terms and conditions of the insurance certificate (see the *Restrictions and Exclusions* section for pre-existing conditions):**
  - **for life and/or disability insurance, if the insured amount for this coverage is $100,000 or less and you are under 55 years of age;**
  - **for critical illness and accidental dismemberment insurance, if the insured amount for this coverage is $50,000 or less and you are under 55 years of age;**

  Go to the *ADDITIONAL INFORMATION* section.
- Complete the *HEALTH DECLARATION:*
  - **for life and/or disability insurance, if the insured amount for this coverage is greater than $100,000 and less than or equal to $500,000;**
  - **for critical illness and accidental dismemberment insurance, if the insured amount for this coverage is greater than $50,000,**
  - **If you are aged 55 years or over.**

  If you answer "No" to all the questions in the Health Declaration, you are insured, subject to the terms and conditions of the certificate (**see *Restrictions and Exclusions* section for pre-existing conditions**) and subject to the accuracy of the information provided.
- **If the insured amount chosen for life insurance is more than $500,000,** go directly to the ADDITIONAL INFORMATION section. A representative of the Insurer will contact you.
- Answering "Yes" to one of the questions does not mean coverage will be automatically declined.
  If in doubt, please check "Yes" and a representative of the Insurer will contact you to complete a detailed questionnaire.

		Applicant Yes	Applicant No
a)	**In the past 3 years:** • **Have you consulted, had a follow-up with or been treated by a physician or another health care professional, or have you taken medication for or had symptoms related to, or do you suffer from any of the following health problems:** - heart disease or circulatory disorders - stroke - chest pain or angina - blood disorders including cholesterol - blood pressure disorders - muscular dystrophy - multiple sclerosis - Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any other disease or disorder of the immune system - tumour or cancer - digestive disorders - liver disorders - intestinal disorders - kidney disorders - urinary tract disorders - lung or respiratory disorders (including sleep apnea) - genital, prostate or breast disorders - neurological disorders - diabetes or glocuse intolerance - psychological or psychiatric disorders (including depression, anxiety, adjustment disorder, etc.) **and for any of the following problems only if you are applying for disability insurance:** - fibromyalgia or chronic fatigue syndrome - carpal tunnel - muscle, joint or bone disorders (including sprains, tendonitis, bursitis, capsulitis, etc.) - neck, back or spinal column problems • **Have you ever used drugs without a medical prescription, or have you received treatment or joined a rehabilitation program because of your alcohol consumption or have you been advised by a health care professional to reduce your consumption of alcohol?**	☐	☐
b)	**In the past 3 years, have you been confined to a hospital due to an accident or illness for more than 48 consecutive hours?**	☐	☐
c)	**In the past 3 years, have you applied for life, disability or critical illness insurance that was subject to an additional premium or refused or issued with a restriction?**	☐	☐
d)	**Only if you are applying for critical illness insurance. Please also complete questions a), b) and c).** **Has one or more members of your biological family (father, mother, brothers or sisters) suffered from diabetes, cancer, a stroke or heart disease before the age of 60?**	☐	☐

ADDITIONAL INFORMATION (To be completed by the applicant)

A representative of the Insurer might contact you. Please indicate the best time and telephone number at which to reach you. If a detailed questionnaire is required, you may choose the desired language. Please indicate your preference:

_____
Choice of language

☐ Day _____ _____ ☐ Evening _____ _____
Telephone No. Ext. Telephone No. Ext.

DECLARATION AND AUTHORIZATION

I UNDERSTAND that insurance is optional and I can cancel it at any time. If I cancel the insurance within 30 days from signing the application, the Insurer will refund all of the premiums paid, if any, and the insurance will never have been effective.

I AGREE to be bound by all the provisions of the group insurance policy and I AUTHORIZE the Insurer and National Bank of Canada to use my Social Insurance Number for administrative purposes.

I CONFIRM it is my wish that this insurance application and the insurance certificate as well as all related documents be drawn up in English. JE CONFIRME ma volonté que cette proposition d'assurance et le certificat d'assurance ainsi que tous les documents s'y rattachant soient rédigés en anglais.

(Quebec only) The French version of this insurance application and the insurance certificate is available here: assurances-bnc.ca/documentation.html, under the Commercial Loan Insurance section. I CONFIRM having received this version. (Québec seulement) La version française de cette proposition d'assurance et du certificat d'assurance est disponible ici : assurances-bnc.ca/documentation.html sous la section Assurance aux entreprises. JE CONFIRME avoir reçu cette version.

I UNDERSTAND that any insurance benefits payable under said group insurance policy shall be paid to National Bank of Canada to be applied against the insured portion of my outstanding debt.

I CERTIFY that all the information provided in this application, including the Health Declaration and the Smoking Status section, is complete and accurate. I UNDERSTAND that any omission or false declaration concerning this application will automatically result in the cancellation of my insurance.

I AUTHORIZE National Bank of Canada to collect the insurance premium amount using the method applicable to the type of loan covered by this application.

I UNDERSTAND that during the period in which evidence of insurability must be provided to the Insurer and **before the Insurer renders a decision regarding my insurability, benefits related to the coverage that I selected will be payable only if the death, disability or accidental dismemberment results from an accident that occurs after the effective date of insurance.**

I AUTHORIZE the Insurer to share my information with its suppliers when insurance related services are available.

I HEREBY UNDERTAKE to advise the Insurer immediately in writing of any change in my personal information so that it can keep its files up to date.

I HEREBY AUTHORIZE any physician, medical practitioner, hospital, clinic, paramedical firm, service provider, agent, insurance company, the MIB Inc. (Medical Information Bureau) or other organization or institution that has any information about me or my health status, to exchange information with the Insurer or its reinsurers. I AUTHORIZE the Insurer or its reinsurers to disclose any information regarding my health status or other relevant information pertaining to me to the MIB Inc.

I AUTHORIZE the Insurer to use any information it has on my account, including information from closed files. This authorization is valid for the period required to achieve the ends for which it was requested. A photographic copy of this authorization shall be as valid as the original.

_____ **X** _____
Date (YYYY MM DD) Applicant signature

I ACKNOWLEDGE THAT I AM AUTHORIZED TO SIGN ON BEHALF OF THE COMPANY. I HAVE RECEIVED AND READ ALL THE PROVISIONS OF THIS INSURANCE APPLICATION AND THE CERTIFICATE OF INSURANCE, INCLUDING THE RESTRICTIONS AND EXCLUSIONS AND HAVING RECEIVED THE SUMMARY.

PRE-AUTHORIZED DEBIT APPLICATION (PAD) – PAYOR PAD AGREEMENT (PADA)

PAD category ☐ Personal ☒ Entreprise

Withdrawal authorization (frequency and amount of debits): I, THE UNDERSIGNED, AUTHORIZE the Insurer, its successors, potential transferees or assigns, to carry out, effective immediately, business PADs in the same account as loan payments or, when specified, in the account designated below, to cover the insurance premiums at the same time as loan payments, as determined by the undersigned.

Each withdrawal corresponds to a fixed amount which can be modified, in particular should the withdrawal of the initial premium not be accepted, or to a variable amount (depending on the insurance product).

WAIVER: I WAIVE THE RIGHT to receive notice indicating the amounts and due dates of debits 10 days prior to the first debit being charged to my account. I ALSO WAIVE THE RIGHT to receive prior written notice of any change to the amount or the debit date, notably when this change results from instructions that I have given to the Insurer to amend the debit terms and conditions.

Change or cancellation: I AGREE to notify the Insurer, at least 5 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.

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 to the Insurer. I may obtain a sample cancellation form, or further information on my right to cancel a PADA at my financial institution where my account is held with the Insurer, or by visiting the Payments Canada website at www.payments.ca. **I RELEASE** the Institution from any liability if the cancellation is not respected, except in the case of gross negligence on its part.

Non-compliant debit and reimbursement: I have certain recourse rights if a debit does not comply with my authorization. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with my authorization. For more information on my recourse rights, I may contact the Insurer, the financial institution where my account is held or visit www.payments.ca.

Personal information: I AGREE AND UNDERSTAND that the personal information contained in my pre-authorized debit application will be disclosed to the financial institution and the Insurer, to the extent that such disclosure is directly related to and necessary for the proper application of regulations related to PADs. This consent is valid as long as my authorization is maintained.

PAYMENT AUTHORIZATION AND INFORMATION ABOUT THE ACCOUNT

To be completed only if the premium has to be collected from another account than the loan payments.

_____
Name and address of the financial institution where the account is held

_____ _____ _____
Account No. Transit Institution No.

Payee of PAD (the insurer)
National Bank Life Insurance Company
1100 Robert-Bourassa Blvd, 5th Floor, Montreal, Quebec H3B 2G7
Telephone: 1-877-871-7500 Fax: 514-394-6604

DECLARATION OF WITNESS

I declare that I was present when this application was completed, that I witnessed the applicant's verbal consent or all signatures, as applicable. I have provided the insured with the Certificate of Insurance and a copy of the summary.

_____ _____ **X** _____ _____ _____ _____
Date (YYYY MM DD) Time (verbal consent) Employee's signature Employee's first and last name Employee No. Transit