NATIONAL BANK INSURANCE

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

INSURANCE APPLICATION FOR CONSUMER LOAN – DEMAND NOTE

Life No. 70008-06 (2019-12-09)

☐ New request ☐ Adding an insured ☐ Refinancing: Previous Loan No.: ____________

LOAN INFORMATION

Client 1 No. ____________ Client 2 No. ____________

Transit ____________ Loan No. ____________

$ ____________ Authorized amount or loan balance as at insurance application date

Date of approval (YYYY MM DD) ____________ Date of disbursement (YYYY MM DD) ____________

IDENTIFICATION

Client 1

Last name ____________ First name ____________

Date of birth (YYYY MM DD) ____________ Sex: ☐ M ☐ F E-mail ____________

Address (No., street, apt., city, province and postal code) ____________

Client 2

Last name ____________ First name ____________

Date of birth (YYYY MM DD) ____________ Sex: ☐ M ☐ F E-mail ____________

Address (No., street, apt., city, province and postal code) ____________

ELIGIBILITY

When applying for insurance, you must, at the time of 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 or endorser.

APPLICATION - WAIVER - INELIGIBILITY

Client 1	I request	I waive	I am not eligible for
Life insurance	☐	☐	☐

Date (YYYY MM DD) ____________ X ____________ Client 1 signature

Client 2	I request	I waive	I am not eligible for
Life insurance	☐	☐	☐

Date (YYYY MM DD) ____________ X ____________ Client 2 signature

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

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If the total of insured loans of the same type is $200,000 and more, complete **ADDITIONAL INFORMATION** only. If the total of insured loans of the same type is $25,000 and more and less than $200,000 or if the person insured is aged 55 or older, complete **HEALTH DECLARATION.**
If the total of insured loans of the same type is less than $25,000 and you are under 55 years of age, you are automatically insured, complete **ADDITIONAL INFORMATION.**

HEALTH DECLARATION

	Client 1 Yes	Client 1 No	Client 2 Yes	Client 2 No
a) In the past three (3) years: • Have you, for any of the following health problems, consulted a health care professional, undergone a medical exam or follow-up, suffered or been diagnosed or are you currently being tested or treated for: - heart disease or circulatory disorders - chest pains or angina - blood disorders including cholesterol - blood pressure disorders - tumours or cancer - muscular dystrophy - multiple sclerosis - Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any other disease or disorder of the immune system - lung disease or respiratory problems - digestive problems - liver disorders - intestinal disorders - kidney disease - urinary tract disorders - genital or breast disorders - neurological disorders (including the carpal tunnel) - diabetes or glucose intolerance - psychiatric or psychological disorders (such as depression, anxiety, overwork, professional burnout, etc.) • **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 three (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 three (3) years, have you applied for life or health insurance that was subject to an additional premium or refused or issued with a restriction?	☐	☐	☐	☐

If the total of all insured loans is $25,000 and more but under $200,000 and you answered *No* to all the questions in the *Health Declaration*, your application will be automatically approved, subject to the accuracy of the information provided.

ADDITIONAL INFORMATION (To be completed by all clients)

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:

Client 1 Choice of language: ____________
☐ Day ____________ Telephone No. ______ Ext.
☐ Evening ____________ Telephone No. ______ Ext.

Client 2 Choice of language: ____________
☐ Day ____________ Telephone No. ______ Ext.
☐ Evening ____________ Telephone No. ______ Ext.

DECLARATION AND AUTHORIZATION

I CERTIFY THAT ALL THE INFORMATION PROVIDED IN THIS APPLICATION, INCLUDING THE HEALTH DECLARATION, IS TRUE. I UNDERSTAND that any ommission or false declaration concerning this application will automatically result in the cancellation of my insurance.

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 Personal Demand note 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 prêt billet à demande. 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 UNDERSTAND that during the period in which evidence of insurability must be provided to the Insurer and **before receipt by the Insurer of all tests or medical forms required by it, benefits shall be payable only if the death results from an accident and occurs within the first 120 days of the date on which premium payments start. This time period is 90 days if any evidence of insurability was never submitted.**

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 AUTHORIZE the Insurer to include my name, address and telephone number in its list for commercial or philanthropic solicitation by it or by any other person to whom it agrees to give such list, while maintaining my right to cancel this authorization at any time by informing the Insurer accordingly either verbally or in writing. I HEREBY UNDERTAKE to advise you immediately in writing of any change in my personal information so that you can keep your files up to date.

I HEREBY AUTHORIZE any physician, medical practitioner, hospital, clinic, paramedical firm, service provider, agent, insurance company, the Medical Information Bureau (MIB Inc.) or other organization or institution that has any information about me or health status, to exchange information with the National Bank Life Insurance Company 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 Medical Information Bureau (MIB Inc.).

I AUTHORIZE National Bank Life Insurance Company 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.

I UNDERSTAND THAT THIS INSURANCE IS OPTIONAL. I ACKNOWLEDGE HAVING RECEIVED AND READ ALL THE PROVISIONS OF THIS INSURANCE APPLICATION AND THE CERTIFICATE OF INSURANCE, INCLUDING THE RESTRICTIONS AND EXCLUSIONS. I ACKNOWLEDGE HAVING RECEIVED THE SUMMARY, AND IN QUEBEC ONLY, THE FACT SHEET. I CHOOSE THE COVERAGE UNDER THIS INSURANCE THAT BEST SUITS MY SITUATION AND FINANCIAL NEEDS.

PRE-AUTHORIZED DEBIT APPLICATION – PAYOR 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, 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, provided the Insurer sends me a written notice at least 10 days before the deadline of the modified withdrawal or to a variable amount depending on the insurance product.

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

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

______ Account No. ______ Transit ______ Institution No.

Payee of pre-authorized debit
National Bank Life Insurance Company
1100 Robert-Bourassa Blvd, 5th Floor, Montreal, Quebec H3B 2G7
Telephone: 1-877-871-7500 Fax: 514-394-6604

______ Date (YYYY MM DD) X ______ Client 1 signature ______ Date (YYYY MM DD) X ______ Client 2 signature

DECLARATION OF WITNESS

I declare that I was present at the completion of this application, and witnessed all signatures, and that I have given the Certificate of Insurance to the Insured and, in Quebec only, I have given a copy of the Summary.

______ Date (YYYY MM DD) X ______ Employee's signature ______ Employee's first and last name

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