

**REASON FOR INSURANCE APPLICATION**

New application       Refinancing a National Bank loan - Previous loan No. \_\_\_\_\_       Adding new coverage

**YOUR PERSONAL INFORMATION**

Last name \_\_\_\_\_ First name \_\_\_\_\_  
 Sex  M  F  
 Date of birth (YYYY MM DD) \_\_\_\_\_ Client No. \_\_\_\_\_  
 Complete address, including postal code \_\_\_\_\_  
 Email \_\_\_\_\_

**LOAN INFORMATION**

Reference No. \_\_\_\_\_ Authorized loan amount \_\_\_\_\_ Approval date \_\_\_\_\_

**CHOICE OF AMOUNT AND INSURED PAYMENT**

**For life insurance**

Authorized loan amount (cannot exceed \$500,000)      or       Chosen insured amount: \_\_\_\_\_ (cannot exceed the authorized amount, or \$500,000)

**For critical illness and accidental dismemberment insurance**

Amount selected for life insurance (cannot exceed \$150,000) \_\_\_\_\_

**For disability insurance**

2% of the loan balance used (cannot exceed \$2,000/month)      or       Selected insured amount, in multiples of \$250: \_\_\_\_\_ (cannot exceed 2% of the balance used, or \$2,000/month)

**ELIGIBILITY**

**You can apply for life insurance if:**

- You are between the ages of 18 and 64; and
- You are living in Canada or in the United States; and
- You are a borrower, co-borrower, guarantor or endorser of the National Bank loan.

**You can apply for critical illness and accidental dismemberment insurance if:**

- You have signed up for life insurance.

**You can apply for disability insurance if:**

- You have signed up for life insurance; and
- You can answer "Yes" to the following 2 questions:

- Did you work 60 hours or more remunerated hours over the past 4 weeks, or if you are self-employed, did you generate gross income of \$10,000 or more over your last fiscal year; and
- Can you confirm that **you are not** on unemployment, a leave of absence or unemployed and that **you are not** receiving income replacement benefits (e.g., benefits as a result of a work-related accident or parental leave)?

**If you answered "No," you CANNOT apply for disability insurance.**

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Current employer's name \_\_\_\_\_ Employed since (YYYY MM DD) \_\_\_\_\_

**TOBACCO USE OVER THE PAST 12 MONTHS**

**Please answer this question honestly and accurately. Otherwise, your insurance will be cancelled.**

Have you used tobacco or a nicotine replacement product, including electronic cigarettes, at least once over the past 12 months?  Yes  No

**APPLICATION – WAIVER – INELIGIBILITY – MANDATORY SIGNATURE**

	I request	I waive	I am not eligible for
Life insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical illness and accidental dismemberment insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disability insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date (YYYY MM DD)

Your Signature (ID:1633421)

**HEALTH DECLARATION - MANDATORY SIGNATURE**

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 National Bank Life Insurance Company will contact you to complete a detailed questionnaire.

**Please answer honestly and accurately. Any false statement could result in the denial of a claim or cancellation of your insurance.**

**IF THE INSURED AMOUNT IS \$50,000 OR LESS AND YOU ARE UNDER 55 YEARS OLD**

**You are insured without having to provide additional proof of insurability. Go to ADDITIONAL INFORMATION.**

**IF THE INSURED AMOUNT IS BETWEEN \$50,001 AND \$500,000 OR IF YOU ARE 55 OR OLDER**

**HEALTH DECLARATION**

Answer the following questions.

Answer "Yes" if at least one of the situations applies to you:

**a) In the past 3 years:**

- **Have you consulted, had a follow-up 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?**

- |  |   |   |                          |                          |
|--|---|---|--------------------------|--------------------------|
| <ul style="list-style-type: none"> <li>- Heart or circulatory disorders</li> <li>- Stroke</li> <li>- Chest pains or angina</li> <li>- Blood disorders including cholesterol</li> <li>- Blood pressure disorders</li> <li>- Muscular dystrophy</li> <li>- Multiple sclerosis</li> </ul> | <ul style="list-style-type: none"> <li>- Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any other disease or disorder of the immune system</li> <li>- Tumour or cancer</li> <li>- Digestive problems</li> <li>- Liver disorders</li> <li>- Intestinal disorders</li> <li>- Kidney disorders</li> </ul> | <ul style="list-style-type: none"> <li>- Urinary tract disorders</li> <li>- Lung or respiratory disorders (including sleep apnea)</li> <li>- Genital, prostate or breast disorders</li> <li>- Neurological disorders</li> <li>- Diabetes or glucose intolerance</li> <li>- Psychological or psychiatric disorders (including depression, anxiety, adjustment disorder, etc.)</li> </ul> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|---|---|--------------------------|--------------------------|

**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 used drugs (including marijuana)? Have you used narcotics exceeding the recommended dosage? Have you received treatment or joined a rehabilitation program because of your alcohol consumption? Have you been advised by a health care professional to reduce your consumption of alcohol? Do you have more than 4 glasses of alcohol per day (28/week)?**

<b>b) In the past 3 years, have you been hospitalized due to an accident or illness for more than 48 consecutive hours?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>c) In the past 3 years, have you applied for life, disability or critical illness insurance that was subject to additional premiums or refused or issued with a restriction?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>d) If you are only applying for critical illness insurance, please also complete questions a), b) and c)</b> 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?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to at least one of the questions, go to ADDITIONAL INFORMATION. A representative of National Bank Life Insurance Company will contact you.

If you answered "No" to all the questions in the HEALTH DECLARATION, YOU ARE INSURED based on the accuracy of the information you provided. You do not need to provide additional proof of insurability.

I acknowledge that I have read and answered the questions in the Health Declaration.

Date (YYYY MM DD)

Applicant's Signature (ID:1633422)

## ADDITIONAL INFORMATION (To be completed by all clients)

A representative of National Bank Life Insurance Company may 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: \_\_\_\_\_

Day \_\_\_\_\_  
Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_

Evening \_\_\_\_\_  
Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_

## YOUR DECLARATION AND AUTHORIZATION - MANDATORY SIGNATURE ON THE NEXT PAGE

### Information that you must read and understand

- I can cancel the insurance within 30 days of signing the application. If I do so, the Insurer will refund all the premiums paid, if any, and the insurance will be considered void.
- Insurance is optional and I can cancel it at any time.
- I am bound by all the provisions of the group insurance policy.
- 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](http://assurances-bnc.ca/documentation.html), under the Personal Line of Credit 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](http://assurances-bnc.ca/documentation.html), sous la section Assurance prêt Marge de crédit. Je confirme avoir reçu cette version.**

### Authorization for your personal information

- I hereby authorize the insurer to use any information it has about me.
- I authorize the insurer and National Bank of Canada to use my social insurance number for administrative purposes. I may revoke my authorization at any time by contacting the insurer.
- I hereby undertake to advise the insurer immediately in writing of any change in my personal information so that it can keep my file 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 to exchange information with the insurer or its reinsurers.
- I authorize the insurer or its reinsurers to disclose any information about me to the MIB Inc. (Medical Information Bureau).
- I authorize the insurer to disclose my contact information and any changes to it that I may subsequently provide, as well as my personal and financial information to National Bank of Canada and its subsidiaries so that they may send me offers, information or invitations likely to be of interest to me.
- I authorize the insurer to disclose my information to its service providers when insurance-related services are available.

### Pre-authorized debit application (PADA)

Personal  Business

### Frequency and amount of debits

- I authorize the Insurer to debit the insurance premiums each month from the bank account indicated below.
- If no account number is indicated in the space provided, I understand that the insurance premiums will be debited from my personal line of credit without notice.

### Payment authorization and information about the bank account

\_\_\_\_\_  
Name of the financial institution where the account is held

\_\_\_\_\_  
Account No. \_\_\_\_\_ Institution No. \_\_\_\_\_ Transit \_\_\_\_\_

#### Payee

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

- I can change the account for the collection of my insurance premiums by contacting the Insurer at 1-877-871-7500.
- The amount of each debit will vary based on a determined premium rate.

### Waiver, changes and recourse

- I waive any other confirmation before the first payment.**
- I waive my right to receive notification should the amount of the debit change.**
- I will notify the insurer at least 5 days before the next scheduled debit, of any changes to the bank account information or to the date of the debit.
- I may revoke my authorization at any time, subject to providing 30 days' notice. If I need additional information on the cancellation process, I may contact National Bank, the insurer or go to [www.payments.ca](http://www.payments.ca).
- I have certain recourse rights if a debit does not comply with this agreement. For example, I am entitled to reimbursement of any debit that is not authorized or is not consistent with this current agreement. If I need additional information on my recourse rights, I may contact National Bank, the insurer or go to [www.payments.ca](http://www.payments.ca).

## YOUR COMMITMENT TO ACCURACY OF INFORMATION

- I confirm that the answers and information provided in this application, including the sections on “Eligibility,” “Tobacco use over the past 12 months” and “Health Declaration” are accurate and complete.
- I understand that any omission or misrepresentation may result in the cancellation of my insurance.
- I have received details on the coverage and the procedure to be followed to submit a claim.
- I have read all the information in this insurance application and the certificate of insurance.
- I confirm that I have received the summary and (in Quebec only) the fact sheet.
- I understand that this insurance is optional. I choose the coverage(s) under this insurance that best suits my situation and financial needs.

Date (YYYY MM DD)

Your Signature (ID:1633441)

## DECLARATION OF WITNESS

I declare that I was present when this application was completed and witnessed all signatures thereon. For enrolment via phone or using an electronic signature: I have provided clear instructions on how to complete and sign this application. I have submitted the summary, the certificate of insurance and (in Quebec only) the fact sheet.

Date (YYYY MM DD)

Employee's first and last name

Transit

No employee of National Bank of Canada or 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.