

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

- New request
 Refinancing: Previous Loan No.: _____
 Adding a protection
 Adding an insured

LOAN INFORMATION

Client 1 No. _____ Client 2 No. _____

Transit _____ Loan No. _____

\$ _____
Authorized amount or loan balance as at insurance application date

Disbursement date (YYYY MM DD) _____

IDENTIFICATION

Client 1

Last name _____ Sex: M F First name _____

Date of birth (YYYY MM DD) _____ E-mail _____

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

Client 2

Last name _____ Sex: M F First name _____

Date of birth (YYYY MM DD) _____ 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.

Disability insurance

- Have signed up for life insurance **and**
- In the past four (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 or expecting to receive income replacement payments, you are not eligible for disability insurance.

Client 1

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

Client 2

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

APPLICATION - WAIVER - INELIGIBILITY

Client 1	I request	I waive	I am not eligible for
Life 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) _____ **X** _____
Client 1 signature

Client 2	I request	I waive	I am not eligible for
Life 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) _____ **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.**

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		Client 2																													
	Yes	No	Yes	No																												
<p>a) In the past three (3) years:</p> <ul style="list-style-type: none"> 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: <table border="0"> <tr> <td>- heart disease or circulatory disorders</td> <td>- Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any other disease or disorder of the immune system</td> <td>- urinary tract disorders</td> <td></td> </tr> <tr> <td>- chest pains or angina</td> <td>- lung disease or respiratory problems</td> <td>- genital or breast disorders</td> <td></td> </tr> <tr> <td>- blood disorders including cholesterol</td> <td>- digestive problems</td> <td>- neurological disorders (including the carpal tunnel)</td> <td></td> </tr> <tr> <td>- blood pressure disorders</td> <td>- liver disorders</td> <td>- diabetes or glucose intolerance</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>- tumours or cancer</td> <td>- intestinal disorders</td> <td>- psychiatric or psychological disorders (such as depression, anxiety, overwork, professional burnout, etc.)</td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>- muscular dystrophy</td> <td>- kidney disease</td> <td></td> <td></td> </tr> <tr> <td>- multiple sclerosis</td> <td></td> <td></td> <td></td> </tr> </table> <p>and for any of the following problems only if I am applying for disability insurance:</p> <ul style="list-style-type: none"> fibromyalgia or chronic fatigue syndrome muscle, joint or bone problems (such as sprains, tendonitis, bursitis, capsulitis, etc.) neck, back or spinal column disorders <ul style="list-style-type: none"> 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? 	- heart disease or circulatory disorders	- Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any other disease or disorder of the immune system	- urinary tract disorders		- chest pains or angina	- lung disease or respiratory problems	- genital or breast disorders		- blood disorders including cholesterol	- digestive problems	- neurological disorders (including the carpal tunnel)		- blood pressure disorders	- liver disorders	- diabetes or glucose intolerance	<input type="checkbox"/> <input type="checkbox"/>	- tumours or cancer	- intestinal disorders	- psychiatric or psychological disorders (such as depression, anxiety, overwork, professional burnout, etc.)	<input type="checkbox"/> <input type="checkbox"/>	- muscular dystrophy	- kidney disease			- multiple sclerosis							
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- muscular dystrophy	- kidney disease																															
- multiple sclerosis																																
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												

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:	Client 2	Choice of language:
<input type="checkbox"/> Day	Telephone No. _____ Ext. _____	<input type="checkbox"/> Day	Telephone No. _____ Ext. _____
<input type="checkbox"/> Evening	Telephone No. _____ Ext. _____	<input type="checkbox"/> 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 omission 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 loan with mortgage security 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 personnel avec garantie hypothécaire. 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 or disability 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

Date (YYYY MM DD) _____ Client 1 signature _____

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(S) 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) _____ 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) _____ Employee's signature _____ Employee's first and last name _____