

**INSURANCE APPLICATION FOR CONSUMER
LOAN – ALL-IN-ONE**

Life, critical illness and accidental dismemberment,
disability

No. 70008B20 (2020-04-19)

REASON FOR INSURANCE APPLICATION

- New loan application Refinancing a National Bank loan: Indicate the refinanced loan No.: _____
- Adding an insured Adding new coverage (You already have life insurance) Linking an insured mortgage loan to an All-In-One

YOUR PERSONAL INFORMATION

Applicant 1 _____ Sex M F
Client No. _____ Date of birth (YYYY MM DD) _____

Last Name _____ First Name _____

Complete address, including postal code _____

Email _____

Applicant 2 _____ Sex M F
Client No. _____ Date of birth (YYYY MM DD) _____

Last Name _____ First Name _____

Complete address, including postal code _____

Email _____

LOAN INFORMATION

Transit _____ Loan No. _____ Authorized loan amount (or loan balance at enrolment) _____ Approval date _____

CHOICE OF AMOUNT AND INSURED PAYMENT

For life insurance

- Authorized loan amount (cannot exceed \$1,000,000) or Chosen insured amount: _____ (cannot exceed the authorized amount, or \$1,000,000)

For critical illness and accidental dismemberment insurance

Chosen amount for life insurance (cannot exceed \$150,000) _____

For disability insurance

- 2% of the loan balance used (cannot exceed \$3,000/month) or A chosen insured amount, in multiples of \$250: _____ (cannot exceed 2% of the amount used, or \$3,000/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 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 have worked 60 or more remunerated hours over the past 4 weeks or, if you are self-employed, you generated a gross employment income of \$10,000 or more over the last fiscal year; and
- You can 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)

Applicant 1 _____ Employed since (YYYY MM DD) _____
Current employer's name _____

Applicant 2 _____ Employed since (YYYY MM DD) _____
Current employer's name _____

APPLICATION – WAIVER – INELIGIBILITY

Applicant 1	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"/>

_____ **X** _____
 Date (YYYY MM DD) Signature Applicant 1

Applicant 2	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"/>

_____ **X** _____
 Date (YYYY MM DD) Signature Applicant 2

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?

Applicant 1		Applicant 2	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INSURABILITY

IMPORTANT

Answer honestly and accurately

Answering “Yes” to one of the questions does not mean coverage will be automatically declined.

Any false statement, whether intentional or not, could result in the denial of a claim or cancellation of your insurance.

If in doubt about the answer you need to provide, it is preferable to answer “Yes”. One of our representatives will then contact you to complete a detailed questionnaire in order to clarify the information.

Identify the category to which you belong using this table:

AMOUNT	AGE	PROCESS
From \$0 to \$150,000	Age 18 to 54	Answer the questions in section A) SIMPLIFIED QUESTION . If at least one of the situations applies to you or in case of doubt: > answer “Yes,” and > complete the C) ADDITIONAL INFORMATION section. One of our representatives will contact you to complete a detailed questionnaire. If you answered “No” to all the questions in the HEALTH DECLARATION, YOU ARE INSURED based on the accuracy of the information you have provided.
From \$0 to \$500,000	Age 55 or older	Answer the questions in section B) HEALTH DECLARATION . In case of doubt: > tick “Yes,” and > complete the C) ADDITIONAL INFORMATION section. One of our representatives will contact you to complete a detailed questionnaire.
From \$150,001 to \$500,000	Age 18 to 54	> complete the C) ADDITIONAL INFORMATION section. One of our representatives will contact you to complete a detailed questionnaire.
From \$500,001 to \$1,000,000	Age 18 to 44	If you answered “No” to all the questions in the HEALTH DECLARATION, YOU ARE INSURED based on the accuracy of the information you have provided. You do not need to provide additional proof of insurability.
From \$500,001 to \$1,000,000	Age 45 or older	Go directly to section C) ADDITIONAL INFORMATION . One of our representatives will contact you to complete a detailed questionnaire.

A) SIMPLIFIED QUESTION	Applicant 1		Applicant 2																													
Have you ever: <ul style="list-style-type: none"> Had cancer, a heart attack or a stroke? Submitted a life, critical illness or disability insurance application that was: <ul style="list-style-type: none"> > refused, deferred or cancelled; or > issued with an exclusion or additional premium? OR Over the past 5 years: <ul style="list-style-type: none"> Did you miss work due to disability for a period of more than 4 consecutive weeks? 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
B) HEALTH DECLARATION																																
a) In the past 3 years:																																
<ul style="list-style-type: none"> 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? <table border="0" style="width:100%"> <tr> <td style="width:33%">- Heart or circulatory disorders</td> <td style="width:33%">- Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any other disease or disorder of the immune system</td> <td style="width:33%">- Urinary tract disorders</td> </tr> <tr> <td>- Stroke</td> <td>- Tumour or cancer</td> <td>- Lung or respiratory disorders (including sleep apnea)</td> </tr> <tr> <td>- Chest pains or angina</td> <td>- Digestive problems</td> <td>- Genital, prostate or breast disorders</td> </tr> <tr> <td>- Blood disorders including cholesterol</td> <td>- Liver disorders</td> <td>- Neurological disorders</td> </tr> <tr> <td>- Blood pressure disorders</td> <td>- Intestinal disorders</td> <td>- Diabetes or glucose intolerance</td> </tr> <tr> <td>- Muscular dystrophy</td> <td>- Kidney disorders</td> <td>- Psychological or psychiatric disorders (including depression, anxiety, adjustment disorder, etc.)</td> </tr> </table> <p>and for any of the following problems, only if you are applying for disability insurance</p> <table border="0" style="width:100%"> <tr> <td style="width:33%">- Fibromyalgia or chronic fatigue syndrome</td> <td style="width:33%">- Muscle, joint or bone disorders (including sprains, tendonitis, bursitis, epicondylitis, osteoarthritis, etc.)</td> <td style="width:33%">- Neck, back or spinal column problems</td> </tr> <tr> <td>- Carpal tunnel</td> <td></td> <td></td> </tr> </table> <ul style="list-style-type: none"> Have you used drugs (including marijuana)? Have you used narcotics exceeding the recommended dosage? Have you ever received treatment or joined a rehabilitation program because of your alcohol consumption? Have you been advised by a health care professional to reduce your alcohol consumption? Do you drink more than 4 glasses of alcohol per day (28/week)? 					- Heart 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	- Stroke	- Tumour or cancer	- Lung or respiratory disorders (including sleep apnea)	- Chest pains or angina	- Digestive problems	- Genital, prostate or breast disorders	- Blood disorders including cholesterol	- Liver disorders	- Neurological disorders	- Blood pressure disorders	- Intestinal disorders	- Diabetes or glucose intolerance	- Muscular dystrophy	- Kidney disorders	- Psychological or psychiatric disorders (including depression, anxiety, adjustment disorder, etc.)	- Fibromyalgia or chronic fatigue syndrome	- Muscle, joint or bone disorders (including sprains, tendonitis, bursitis, epicondylitis, osteoarthritis, etc.)	- Neck, back or spinal column problems	- Carpal tunnel			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Carpal tunnel																																
b) In the past 3 years, have you been hospitalized 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 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
d) If you are only 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												

I confirm that I have read the Simplified Question or the questions in the Health Declaration and have answered it myself.

X

Signature Applicant 1

Date (YYYY MM DD)

X

Signature Applicant 2

Date (YYYY MM DD)

C) 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 phone number at which to reach you.

Please note: although the questions regarding "insurability" pertain to your most recent history (3 to 5 years), our representatives may have questions about a longer timeframe.

Applicant 1

If a detailed questionnaire is required, you may choose the desired language.

Please indicate your preference: _____

Day _____ Evening _____
 Phone No. _____ Ext. _____ Phone No. _____ Ext. _____

Applicant 2

If a detailed questionnaire is required, you may choose the desired language.

Please indicate your preference: _____

Day _____ Evening _____
 Phone No. _____ Ext. _____ Phone No. _____ Ext. _____

