

INSURANCE APPLICATION FOR CONSUMER LOAN – ALL-IN-ONE

Life, critical illness and accidental dismemberment, disability

No. 70008B20 (2020-04-19)

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

REASON FOR INSURA	ANCE APPLICATION			
☐ New loan application	Refinancing a National Bank loan: Indicate the	e refinanced loan No.:		
☐ Adding an insured	☐ Adding new coverage (You already have life in	nsurance) 🔲 Linking	g an insured mortgage	e loan to an All-In-One
YOUR PERSONAL INF	FORMATION			
Applicant 1 Client N	No.		Date of birth (YYYY M	Sex M F
Last Name		First Name		
Complete address, including p	ostal code			
Email		_		
Applicant 2 Client N	No.		Date of birth (YYYY M	Sex M F
Last Name		First Name		
Complete address, including p	ostal code			
Email		1 1 1		
LOAN INFORMATION				
Transit	Loan No. Autho	rized loan amount (or loan balar	nce at enrolment)	Approval date
CHOICE OF AMOUNT	AND INSURED PAYMENT			
For life insurance				
Authorized loan amo (cannot exceed \$1,000		Chosen insured amo		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 balar (cannot exceed \$3,000		A chosen insured ar (cannot exceed 2% of		
ELIGIBILITY				
 You are a borrower, co You can apply for critical or an apply for disal or an apply for disa	ages of 18 and 64; and da or the United States; and o-borrower, guarantor or endorser of the Natio ical illness and accidental dismemberment or life insurance. ability insurance if:	insurance if: weeks or, if you are seence or unemployed and		
Applicant 1 Current	employer's name			Employed since (YYYY MM DD)
Applicant 2	employer's name			Employed since (YYYY MM DD)

APPLICATION - WAIVER - INELIGIBILITY						
Applicant 1	I request	I waive	I am not eligible for			
Life insurance						
Critical illness and accidental dismemberment insurance						
Disability insurance						
Date (YYYY MM DD) X Signature Applicant 1 Applicant 2	I request	I waive	I am not eligible for			
Life insurance		Walve				
Critical illness and accidental dismemberment insurance						
Disability insurance						
Date (YYYY MM DD) X 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?

Applic	cant 1	Applicant 2			
Yes	No	Yes	No		

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:

, , ,	willion you belong	
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.
F #0 to #500 000	And EE an olden	Answer the questions in section B) HEALTH DECLARATION.
From \$0 to \$500,000	Age 55 or older	In case of doubt:
		> tick "Yes," and
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	I 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 Q	QUESTION				Appli	cant 1	Appli	cant 2
Hav	e you ever:								
		ncer, a heart attack or a stroke?		4h4					
	· Submitti	ted a life, critical illness or disab refused, deferred or cancelled		on that was:					
	>	issued with an exclusion or a	•						
Ove	er the past 5 y		aditional promium or						
		miss work due to disability for	a period of more than 4	consecutive weeks?					
B) I	HEALTH DEC	I APATION							
,	In the past 3								
۵,	-		on treated by a physici	an or another health	care professional, or have you				
		ation for or had symptoms relat							
	- Heart or cir	rculatory disorders	- Acquired Immune Def		- Urinary tract disorders				
	- Stroke		(AIDS), Human Immu	nodeficiency Virus ease or disorder of the	- Lung or respiratory				
	- Chest pain	•	immune system	sace of alcorder of the	disorders (including sleep apnea)				
		rders including cholesterol	- Tumour or cancer		- Genital, prostate or breast				
	•	sure disorders	 Digestive problems 		disorders				
	- Muscular d	• • •	- Liver disorders		- Neurological disorders				
	- Multiple sc	ierosis	- Intestinal disorders		- Diabetes or glucose intolerance				
			 Kidney disorders 	\	- Psychological or psychiatric				
					disorders (including				
					depression, anxiety, adjustment disorder, etc.)				
	and for any	of the following problems, only	if you are applying for di	sability insurance	disorder, etc.)				
	- Fibromyalg	gia or chronic fatigue syndrome	- Muscle, joint or bone	disorders	- Neck, back or spinal				
	- Carpal tuni	nel	(including sprains, tendor epicondylitis, osteoarthrit		column problems				
•	Have you us	sed drugs (including marijuana))? Have you used narco	tics exceeding the re	ecommended dosage? Have you				
	ever receive	d treatment or joined a rehabilit	ation program because of	of your alcohol consu	imption? Have you been advised han 4 glasses of alcohol per day				
b)	In the past 3	years, have you been hospitaliz	zed due to an accident o	r illness for more that	n 48 consecutive hours?				
c)		3 years, have you applied for refused or issued with a restric		cal illness insurance	that was subject to additional				
d)	If you are on	nly applying for critical illness in	surance, please also cor	nplete questions a), l	o) and c).				
•	-				d from diabetes, cancer, a stroke or				
		e before the age of 60?		,	, ,				
l co	nfirm that I ha	ave read the Simplified Question	or the questions in the	Health Declaration ar	nd have answered it myself.				
X				<u> X</u>					
Signa	ature Applicant 1	1	Date (YYYY MM DD)	Signature Applicant	2	Date	(YYYY	MM D	D)
C) /	ADDITIONA	L INFORMATION (To be com	pleted by all clients)						
A re	presentative o	of National Bank Life Insurance Co	mpany may contact you. F	Please indicate the bes	t time and phone number at which to	reach	you.		
Plea	se note: altho	ough the questions regarding "ins	surability" pertain to your r	nost recent history (3	to 5 years), our representatives ma	y have	quest	ions a	bout a
long	er timeframe.								
App	licant 1	If a detailed questionnaire is req	uired, you may choose the	desired language.					
		Please indicate your preference:	:						
		☐ Day		☐ Evenin	g				
		Phone No.	Ext.	[[[Verilli	Phone No.		Ext		
۸n-	licant 2	If a detailed questionnoire is rea	uired you may chasse the	desired language					
∼hb	licant 2	If a detailed questionnaire is req Please indicate your preference:	• •	• •					
		i isase indicate your preference.	·						
		Day		Evenin			· <u>-</u>		
		Phone No.	Ext.		Phone No.		Ext	-	

YOUR DECLARATION AND AUTHORIZATION

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 as of June 1st, 2023) The French version of this insurance application and the insurance certificate is available here: assurancesbnc.ca/documentation.html, under the All-In-One Loan Insurance section. I confirm having received this version. (Québec seulement - à partir du 1er juin 2023) La version française de cette proposition d'assurance et du certificat d'assurance est disponible ici: <u>assurances-bnc.ca/documentation.html</u>, sous la section Assurance prêt Tout-En-Un. 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 Medical Information Bureau (MIB LLC.) 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 Medical Information Bureau (MIB LLC.).
- 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)

Business

Frequency and amount of debits

- I authorize the insurer to debit the insurance premiums from the bank account used for the loan payments at the same frequency as the loan payment.
- Each debit corresponds to a variable amount 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.
- 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.

YOUR COMMITMENT TO ACCURACY OF INFORMATION

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

x		X	
Date (YYYY MM DD) Signature Applicant 1	Date (YYYY MM DD)	Signature Applicant 2	
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 fact sheet, certificate of insurance and the summary.

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