La Capitale

MODIFICATION PILLAR SERIES

Contract number

In this application form, "the Insurer" means La Capitale Financial Security Insurance Company.

INSTRUCTIONS

Important: Check the desired changes.

☐ Change of name	Complete sections 1, 2 and 13.
☐ Change of payment method	Complete sections 1, 4, 5 (if applicable) and 13.
☐ Change of beneficiary	Complete sections 1, 3, 12 (if applicable) and 13.
☐ Decrease in monthly benefit amount(s)	Complete sections 1, 6 and 13.
☐ Increase in elimination period(s)	Complete sections 1, 7 and 13.
☐ Decrease in benefit period(s)	Complete sections 1, 8 and 13.
☐ Cancellation of one or more riders	Complete sections 1, 9, 12 (if applicable) and 13.
☐ Cancellation of the contract (including the base policy and any attached riders)	Complete sections 1, 9, 12 (if applicable) and 13. If requesting the cancellation of a contract including Accidental Death or Safe Driver coverage, complete section 12 only if the designation of beneficiary is irrevocable.
☐ Review of an exclusion	Complete sections 1, 10 and 13, and attach the Declaration of Insurability form required for the policy coverage type.
☐ Review of extra premium	Complete sections 1, 10 and 13, and attach the Declaration of Insurability form required for the policy coverage type.
☐ Request for a non-smoker rate	Complete sections 1, 10 and 13, and attach the Declaration of Insurability form required for the policy coverage type. To request a non-smoker rate, the policyholder/insured must be able to answer No to section 10.
☐ Request for a guaranteed benefit	Complete sections 1, 11 and 13, and attach proof of income for the last two years.
Request for reinstatement of a policy within 90 days after the due date of the unpaid premium	Do not complete this form, but rather the Reinstatement form (IND137E) and the Declaration of Insurability form required for the policy coverage type. Pay the outstanding premiums and any other outstanding amount due. A policy cannot be reinstated more than 90 days after the due date of the unpaid premium. If necessary, submit a new application.
Any other contract change requests	Submit a new application.

1 INFORMATION CONCERNING THE POLICYHOLDER/INSURED

Policyholder/insured's last name

Policyholder/insured's first name

Date of birth: Year Month Day

Occupation

Address (Is this a new address? ○ Yes ○ No)

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5

IND038E (06-2018)

2 CHANGE OF NAME

Proof of identity is always required, except if the only change involves removal of one of the two last names currently in the contract.

○ Policyholder/insured ○ Beneficiary

Former first name (as indicated in our records) _____ Former last name (as indicated in our records) _____

New first name _____ New last name _____

Reason for change:

○ Marriage: ____ ____ ____ (Year Month Day) ○ Divorce: ____ ____ ____ (Year Month Day)

○ Resumption of name at birth

○ Court order granting the name change (attach a copy of the order)

○ Other: _____

3 CHANGE OF BENEFICIARY (for the Accidental Death rider or Safe Driver coverage)

Revocable and irrevocable beneficiaries: A beneficiary designation is revocable unless otherwise indicated. However, in Quebec if the named beneficiary is the person to whom the policyholder/insured is married or civilly united, this designation is considered irrevocable unless the policyholder/insured indicates that he or she wishes for the designation to be REVOCABLE.

Designating an irrevocable beneficiary can have significant consequences. To replace a beneficiary designated as irrevocable, or carry out certain changes or transactions, the beneficiary's consent must be obtained. A minor irrevocable beneficiary cannot consent to a change or transaction, and the minor irrevocable beneficiary's parents and legal guardian are also unable to sign a document in that regard on his or her behalf.

Minor beneficiary: Outside Quebec, if a minor is the designated beneficiary, it is recommended that a trustee also be designated. By naming a trustee, the benefit is payable to the trustee who will hold it in trust for the minor beneficiary until he or she is of legal age (not applicable in Quebec). In Quebec, the minor beneficiary's legal guardian will receive the payable benefit unless an official trustee has been named.

Estate, successors and legal heirs: The terms "estate", "successors" or "legal heirs" refer to the policyholder/insured's estate, successors or legal heirs.

BENEFICIARY

Last name	First name	Date of birth (Year Month Day)	Relationship to the policyholder/insured	Check one: Revocable	Check one: Irrevocable	Share % Total: 100%
				○	○	
				○	○	
				○	○	

(Registration of this beneficiary designation in the Insurer's records does not guarantee its validity or lawfulness.)

4 CHANGE OF PAYMENT METHOD

○ Annual

○ Semi-annual Not offered for Simplified Accident insurance.

○ Preauthorized debit (PAD) Complete the PAD Agreement in section 5.

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5

IND038E (06-2018)

5 PREAUTHORIZED DEBIT (PAD) AGREEMENT

PREMIUM PAYOR'S INFORMATION

◯ Policyholder/insured ◯ Other: ◯ Mr. ◯ Ms. _____ _____
First name Last name

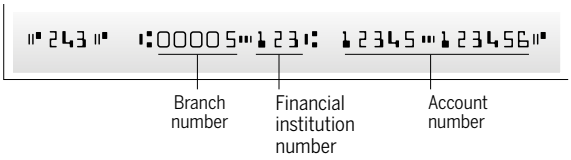
_____ _____
Address (No., street, apt., city, province) Postal code

_____ Date of birth: _____
Tel. Year Month Day

◯ Business: _____ _____
Company name Tel.

_____ _____
Address (No., street, city, province) Postal code

BANK ACCOUNT INFORMATION: ◯ Cheque specimen attached to the application ◯ Bank account information provided below:



Branch number _____ Financial institution number _____ Account number _____

PAD TYPE: ◯ Personal ◯ Business

WITHDRAWAL DATE: The _____ of each month (between the 1st and 30th days of the month). If a date is not indicated, it will be selected by the Insurer.

I waive my right to receive advance notice of the amount and the date of the PAD and of any change to the amount and the date. This agreement may be cancelled upon receipt by the Insurer of 10 days' written notice prior to the scheduled date of the next PAD. To obtain a PAD cancellation form, or for more information about your right to cancel this agreement, contact your financial institution or visit www.cdnpay.ca. You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information about your recourse rights, contact your financial institution or visit www.cdnpay.ca. I authorize the Insurer or its agent to debit the fixed monthly amounts required for payments due to the Insurer from the account indicated on the enclosed cheque specimen or from the account identified above.

✗ _____ _____
Signature of premium payor Date

La Capitale Insurance and Financial Services
625 Jacques-Parizeau St, Quebec QC G1R 2G5
Tel.: 418 528-2211 or 1 800 463-4433 | Email: fim@lacapitale.com

6 DECREASE IN MONTHLY BENEFIT AMOUNT(S)

The total monthly benefits payable in the event of sickness may not be greater than the total monthly benefits payable in the event of accident.

			Increments of $100
◯ Accident Only Disability base policy	from $ _____	to $ _____	(minimum of $500)
◯ Accident Only Disability rider (additional coverage)	from $ _____	to $ _____	
◯ Sickness Only Disability rider	from $ _____	to $ _____	(minimum of $500)
◯ Sickness Only Disability rider (additional coverage)	from $ _____	to $ _____	

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5

IND038E (06-2018)

7 INCREASE IN ELIMINATION PERIOD(S)

Elimination periods in the event of sickness may not be less than elimination periods in the event of accident.

Is the policyholder/insured paying Employment Insurance (EI) premiums? ○ Yes ○ No

☐ Accident Only Disability base policy	from	○ 0 day ○ 14 days ○ 30 days ○ 90 days	to	○ 14 days ○ 30 days ○ 90 days ○ 120 days	Not offered for Simplified Accident insurance. Available only if the policyholder/insured is paying EI premiums.
☐ Accident Only Disability rider (additional coverage) This change is not available if the policyholder/insured is paying EI premiums.	from	○ 0 day ○ 14 days ○ 30 days	to	○ 14 days ○ 30 days ○ 90 days	Not offered for Simplified Accident insurance.
☐ Sickness Only Disability rider	from	○ 14 days ○ 30 days ○ 90 days	to	○ 30 days ○ 90 days ○ 120 days	Available only if the policyholder/insured is paying EI premiums.
☐ Sickness Only Disability rider (additional coverage) This change is not available if the policyholder/insured is paying EI premiums.	from	○ 14 days ○ 30 days	to	○ 30 days ○ 90 days	

8 DECREASE IN BENEFIT PERIOD(S)

Benefit periods in the event of sickness may not be greater than benefit periods in the event of accident.

☐ Accident Only Disability base policy	from	○ 5 years ○ to age 65 ○ to age 70	to	○ 2 years ○ 5 years
☐ Accident Only Disability rider (additional coverage)	from	○ 5 years ○ to age 65 ○ to age 70	to	○ 2 years ○ 5 years
☐ Sickness Only Disability rider	from	○ 5 years ○ to age 65	to	○ 2 years ○ 5 years
☐ Sickness Only Disability rider (additional coverage)	from	○ 5 years ○ to age 65	to	○ 2 years ○ 5 years

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5

9 CANCELLATION OF CONTRACT OR OF ONE OR MORE RIDERS

☐ Accident Only Disability rider (additional coverage)	
☐ Sickness Only Disability rider	
☐ Sickness Only Disability rider (additional coverage)	
☐ All Accident rider (Safe Driver coverage)	
☐ Accidental Death or Dismemberment	If the designation of beneficiary is irrevocable, complete section 12.
☐ Accidental Fracture	
☐ Hospital Accident	
☐ Hospital Sickness	
☐ Partial Disability	Applies only to Simplified Accident insurance. Once cancelled, this rider may not be subsequently added. For the Income Protection insurance, partial disability benefits are included in the base policy. Therefore, Income Protection insurance partial disability may not be cancelled.
☐ Future Insurability Option	Once cancelled, this rider may not be subsequently added.
☐ Indexation Option	Once cancelled, this rider may not be subsequently added.
☐ Regular Occupation Extension	Checking this change will result in the cancellation of any Accident and Sickness Regular Occupation Extension riders. Once cancelled, these riders may not be subsequently added.
☐ Return of Premium	The cancellation of this rider automatically cancels the policy and all other riders attached to it.
☐ Cancellation of the contract (including the base policy and any attached riders)	If requesting the cancellation of a contract including Accidental Death or Safe Driver coverage, complete section 12 only if the designation of beneficiary is irrevocable.

10 TOBACCO USE (review of an exclusion or an extra premium or request for a non-smoker rate)

In the last 12 months, have you smoked cigarettes, cigarillos, cigars, a pipe, a bong, a hookah or used betel nut, snuff or marijuana (cannabis) containing any tobacco or nicotine product or used any other form of tobacco or a substitute such as gum, nicotine patch or electronic cigarette?
◯ Yes ◯ No **If so**:

Type	**Quantity**	**Frequency**

If you quit smoking in the last 12 months, indicate the date: ____ ____
Year Month

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5

IND038E (06-2018)

11 EMPLOYMENT AND INCOME INFORMATION (request for a guaranteed benefit)

SALARIED EMPLOYEE

Provide income tax declarations for the last two years.

Occupation: _____

Function: _____

Employer's name: _____

Employer's address: _____

_____

Number of years with current employer: _____

Number of years of related experience: _____

Number of hours worked per week: _____

Number of months worked per year: _____

Indicate the percentage of your work devoted to:

- Driving _____ %
- Supervision _____ %
- Office or administrative work _____ %
- Manual work _____ %
- Other: _____ _____ %

Indicate the percentage of your work spent:

- At home _____ %
- Away from home _____ %

Gross annual income in the current year: $ _____

SELF-EMPLOYED AND BUSINESS OWNER

Provide income tax forms (T1 General) and business financial statements or the Statement of Business or Professional Activities, as applicable, for the last two years.

Occupation: _____

Function: _____

Employer's name: _____

Employer's address: _____

_____

Number of years in business: _____

Number of years of related experience: _____

Type of business:
- ○ Sole owner
- ○ Corporation
- ○ Partnership

Number of employees:
- Full-time: _____
- Part-time: _____
- Seasonal: _____

Number of hours worked per week: _____

Number of months worked per year: _____

Indicate the percentage of your work devoted to:

- Driving _____ %
- Supervision _____ %
- Office or administrative work _____ %
- Manual work _____ %
- Other: _____ _____ %

Indicate the percentage of your work spent:

- At home _____ %
- Away from home _____ %

Indicate the percentage of the policyholder/ insured's interest in the business: _____ %

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5

IND038E (06-2018)

12 CONSENT OF IRREVOCABLE BENEFICIARY (if applicable)

In the event of a beneficiary change to the Accidental Death rider or the Safe Driver coverage, I agree that my designation as beneficiary be revoked.

In the event the Accidental Death rider or the Safe Driver coverage is cancelled, I consent to this cancellation request by the policyholder/insured of this contract.

Signed at _____ on this _____ day of _____ 20_____.

X _____ _____

Signature of irrevocable beneficiary | Name of irrevocable beneficiary (please print)

(Registration of this change of beneficiary in the Insurer's records does not guarantee its validity or lawfulness.)

13 DECLARATION AND SIGNATURES

IMPORTANT NOTICE CONCERNING THE RETURN OF PREMIUM RIDER

If the change requested reduces the premium and the contract impacted by this request contains a Return of Premium rider, the return of premium amount will be calculated based on the reduced premium, retroactively to the original effective date of the Return of Premium rider.

The policyholder/insured hereby acknowledges and agrees that the answers in this form are true and complete.

If the contract impacted by this request contains a Return of Premium rider, the policyholder/insured hereby acknowledges having read and understood the important notice concerning the Return of Premium rider.

The policyholder/insured hereby acknowledges that this request, accompanied by any Declaration of Insurability form submitted to the Insurer, is used as the basis of the change requested and is an integral part of the contract.

The Insurer is hereby authorized to proceed with the change requested in the usual manner, as it considers appropriate.

Signed at _____ on this _____ day of _____ 20_____.

X _____

Signature of policyholder/insured

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5