

Policy number _____

General Information

Type of request

- ☐ Reinstatement (complete sections 1, 2 and the other applicable sections)
- ☐ Modification (complete sections 1, 2, 3 and 5)
- ☐ Cancellation (complete sections 1, 2, 3 and 5)

Section 1: Insured

First Name

Last Name

Y

Y

Y

Y

M

M

D

D

Date of birth

Age

Sex

☐ Female☐ Male

Name at birth (if different)

Apt.

City

Address

Apt.

City

Province

Postal Code

Telephone (home)

Telephone (other)

Preferred Language

☐ English☐ French

Section 2: Policyowner (complete if the policyowner is not the insured)

First Name

Last Name

Y

Y

Y

Y

M

M

D

D

Date of birth

Relationship to insured

Name at birth (if different)

Apt.

City

Address

Apt.

City

Province

Postal Code

Telephone

Subsidiary policyowner (if applicable)

First Name

Last Name

Y

Y

Y

Y

M

M

D

D

Date of birth

Relationship to insured

Section 3: Benefit(s) Requested

Name of Benefit	Nature of Application	Basic Indemnity	Benefit Period	Modal Premium
Disability due to accident benefit	<input type="checkbox"/> Reduction of Capital <input type="checkbox"/> Reinstatement <input type="checkbox"/> Cancellation	<input type="checkbox"/> \$500 / month <input type="checkbox"/> \$1,000 / month	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months	\$
Hospitalization due to accident benefit	<input type="checkbox"/> Reduction of Capital <input type="checkbox"/> Reinstatement <input type="checkbox"/> Cancellation	<input type="checkbox"/> \$50 / day <input type="checkbox"/> \$100 / day		\$
Accidental death and dismemberment benefit	<input type="checkbox"/> Reduction of Capital <input type="checkbox"/> Reinstatement <input type="checkbox"/> Cancellation	<input type="checkbox"/> \$25,000 – \$50,000 <input type="checkbox"/> \$50,000 – \$100,000		\$
Benefit in case of fracture	<input type="checkbox"/> Reduction of Capital <input type="checkbox"/> Reinstatement <input type="checkbox"/> Cancellation	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000		\$
Basic Contractual Premium				\$
Total AcciGuard Premium				\$

Section 4: Eligibility Criteria

- The person to be insured must meet the eligibility criteria of Beneva Inc. At the time of reinstatement, the applicant is eligible if he / she:
1.

Is a permanent Canadian resident or an accepted immigrant and has been living in Canada for at least 2 years; and
2.

Does not stay in a hospital or in a health care facility or in a convalescent home; and
3.

Is not in a state of **total and permanent disability or in total disability**.

Section 5: Declaration and Signatures

The undersigned:

- 1. Certify to have understood and met the eligibility criteria above.
- 2. Agree that this declaration serves as the base to the requested insurance policy or to the policy this change request refers to.
- 3. **Declare to have read the summary of EXCLUSIONS related to the benefits.**
- 4. Understand that for the DISABILITY DUE TO ACCIDENT BENEFIT, **only a total disability following an accident resulting in hospitalization, fracture, severe burns, laceration, dismemberment or internal bleeding will be covered under this benefit.**
- 5. Have read the **Notice to the proposed insured(s) and policyowner(s)** regarding personal files and personal information and understand that the information shall be treated as confidential and confined in the insured's file as mentioned in the latter notice.
- 6. Declare that the aforesaid declarations are true and form part of the present **Policy change** form with Beneva Inc. Any misrepresentation or concealment by the proposed insureds regarding circumstances that are known to the proposed insured and likely to have a material influence on an insurer with respect to setting of premium, the appraisal of risk or the decision to cover it, shall cause the contract, at the insurer's request, to become void even with respect to any losses not connected with the risks so misrepresented or concealed.

Signed at (city and province)

X

Signature of insured or signature of the father, mother or legal representative, if a minor insured

Amendment to be sent to ☐ Advisor ☐ Policyowner Amount of cheque \$ _____

| Y , Y , Y , Y | M , M | D , D |

Date

X

Signature of policyowner or authorized person

Section 6: Pre-Authorized Debit Agreement

- 1. I hereby authorize Beneva Inc. to debit my account as per my instructions and/or as detailed in the contract of insurance, for monthly recurring payments and/or one time payments from time to time, in payment of all charges, including any applicable financing charges and taxes, arising from the contract of insurance.
- 2. The amount of the pre-authorized debit may be increased or decreased at a later date as a result of endorsements, cancellation, exclusions or renewal of the contract of insurance. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as variable amount pre-authorized debits. I understand that the same method of payment will apply upon renewal of the contract of insurance, if applicable, unless I notify Beneva Inc. before the renewal date of the contract of insurance.
- 3. I understand that a financing charge may be applicable and spread over the instalments.
- 4. If a pre-authorized payment is returned due to insufficient funds (NSF), Beneva Inc. is authorized to re-submit the payment. Any charges incurred as a result of NSF may be added to the subsequent pre-authorized payment.
- 5. I agree to inform Beneva Inc., by way of a letter, of any change in the account information provided in this Agreement at least ten (10) business days prior to the next debit to my account.
- 6. I agree to the debiting of my account each month on the day selected in the insurance application or the next business day.
- 7. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as Personal.
- 8. **I agree and understand that Beneva Inc. will not notify me before each withdrawal.**
- 9. In the event that I instruct Beneva Inc. to change the amount of the pre-authorized debit, I waive the right to receive the required notice.
- 10. I may cancel this authorization for pre-authorized debits at any time, subject to providing Beneva Inc. with thirty (30) days notice in writing. I may contact my financial institution about my rights regarding cancellation, or visit www.cdnpay.ca for a sample cancellation form.
- 11. I understand that Beneva Inc. reserves the right to terminate this Agreement upon fifteen (15) days notice in writing.
- 12. Any cancellation of this Agreement will not terminate or otherwise have any bearing on any Agreement that exists with Beneva Inc. whatsoever with respect to any contract of insurance, so long as payment is provided by an alternate method accepted by Beneva Inc.
- 13. I have certain recourse rights if any 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 Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Beneva Inc.
Premium Accounting
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

Please attach a cheque specimen, on which you have written "CANCELLED", for the account to be debited.



Name of financial institution

Address, city, province and postal code of the branch

Branch

Financial institution number

Account number

Authorization

For a joint account, all account holders must sign if more than one signature is required on cheques issued from the account.

Name of account holder or authorized person
(in capital letters)

X
Signature

| Y , Y , Y , Y | M , M | D , D |
Date

Name of account holder or authorized person
(in capital letters)

X
Signature

| Y , Y , Y , Y | M , M | D , D |
Date

Policy number _____

Section 7: Signature of representative / Financial security advisor

I confirm that I have provided an “Advisor Disclosure Statement” to the policyowner disclosing the following:

- the company or companies I represent at this moment;
- that I will receive compensation such as commissions for the sale of life and health insurance company products;
- that I may receive additional compensation in the form of bonuses, conference programs or other incentives; and
- that I have disclosed any conflict of interest that I may have with respect to this transaction.

I declare that I have a valid licence for the territory where this application has been signed.
I hereby declare that all information in this application is true and complete to the best of my knowledge.

X

Name of authorized representative / financial security advisor
(in capital letters)

Signature of authorized representative / financial security advisor

Y

Y

Y

Y

M

M

D

D

Date

Section 8: Information about representative / Financial security advisor

The following information is necessary for the request to be processed and for commissions to be paid.

Name of representative / financial security advisor (capital letters)	Agency	Code of representative / financial security advisor	Share %	Telephone number
Service advisor				
Other advisor to be paid (if applicable)				

This notice must always be given to the policyowner.

Policy number _____

Section 9: Notice to the proposed insured(s) and policyowner(s)

Notice regarding the protection of your personal information

Protecting your personal information is a priority for Beneva¹. For this reason, we want to inform you that we collect, use and disclose your personal information only with your consent, unless otherwise permitted by law, and only for the time necessary to:

- identify you
- establish and update your profile, needs and objectives
- evaluate your applications and eligibility for our products and services
- provide you with advice related to your situation
- administer your contracts as well as your products or services (e.g. : pricing, underwriting, enrolment, claims processing, etc.)
- comply with legal and regulatory requirements (e.g. : preventing, detecting or deterring violations, cyber threats, fraud, etc.)
- obtain your feedback on our products and services
- provide you with personalized offers and advice about our products and services (refer to your right to withdraw consent) based on your preferences and in compliance with the rules governing electronic and telephone communications
- conduct studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you

How does Beneva collect your personal information?

We may collect your personal information over the telephone, in person, and through the use of our forms and our digital platforms.

Who does Beneva share your personal information with?

For the purposes described above, and only in connection with your products and services, we share your personal information with our affiliates and distribution networks and with third parties, some of which may be located outside of Quebec and Canada.

These third parties may include:

- other financial institutions, such as insurers and reinsurers
- other organizations or entities that have information about you, including insurance, fraud or claims information
- intermediaries
- credit assessment agencies
- government departments, agencies or regulatory authorities
- employers
- claims-related service providers, such as healthcare professionals and auto repair shops
- other agents and service providers (technology services, printing and mailing services, etc.)

Please note that in all cases, we ensure that they respect the protection of your personal information.

What are your rights regarding access and rectification?

You may access your personal information or request the correction of incomplete or inaccurate information. Send us a request to the following address:

Personal Information Protection Officer
Beneva
625 rue Jacques-Parizeau
Quebec QC G1R 2G5
ResponsablePRP@beneva.ca.

For more information about our personal information protection practices, please refer to the complete version of our Personal Information Protection Statement at www.beneva.ca.

Your consent for the collection, use and disclosure of your personal information is necessary in order to provide the product or service requested or offered. You have the right to withdraw your consent, but Beneva will not be able to continue providing you with its products or services.

1. The term “Beneva” refers to Beneva Inc., its affiliates and their mutual insurance companies and distribution networks. Affiliates of Beneva Inc. designates La Capitale Financial Security Insurance Company, Beneva Investment Services Inc., Beneva Insurance Company Inc., L’Unique General Insurance Inc. and Unica Insurance Inc.