beneva

Individual insurance

Policy application

For the following products:

- Simplified Life Insurance
- Guaranteed Issue Life Insurance

Version: Octobre 2023

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

Table of Contents

beneva

Application – Individual insurance

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

	T 853 982 002
Policy number	Application number

A – Basic information

- For more than 1 insured, use additional applications as required.
- **Please submit ALL the pages of this application, even if there is no information written on certain pages.**
- New applications are only permitted electronically.

☐ New application **(available as an electronic application only)** ☐ Policy change ☐ Reinstatement

Language of correspondence: ☐ English ☐ French

Policy changes

If there is more than one policyowner, EACH policyowner must sign Section K of this application.

☐ **Change to non-smoker rates**
Please complete Sections B1, B2, G, H, I, J, K, M and O.

☐ **Change of benefit**
To request an increase in face amount, please complete a new application.
For a reduction in face amount, please complete the *Policy change without evidence of insurability* form (FIND0116A).

☐ **Change of beneficiary**
For any change of beneficiary request, use the *Change of beneficiary(ies)* form (FIND0205A).

☐ **Change of policyowner**
For any change of policyowner request, use the *Transfer of Ownership (Absolute Assignment)* form (FIND0206A).

☐ **Conversion of a Simplified Term Life product to a Simplified Whole Life**
Please complete the *Policy change without evidence of insurability* form (FIND0116A).

☐ **Reinstatement**
For any reinstatement request, complete Sections B1, B2, B3, B4, D1, E, F, G, H, I, J, K, L, M, N and O.

B – General information

B1 – Proposed insured

- The first name and last name will appear on the insurance contrat as indicated in this section.

Insured

☐ Mr. ☐ Mrs. ☐ Ms.

First name

Last name

Name at birth (if different)

Date of birth (Y Y Y Y M M D D)

Age*

☐ Male ☐ Female
Sex

Place of birth (city and country)

* Age at nearest birthday, that is six (6) months before or after the date the application is signed.

Residential Address

Civic number and street name

Apt.

City

Province

Postal code

Telephone (residence)

E-mail address (internet)

B2 – Employment details

Insured

Details of Profession/Occupation (if retired, indicate the last profession and field of activity)

B3 – Policyowner(s)

- **When the policyowner(s) are not indicated, we consider that it corresponds to the insured - Maximum 2 policyowners per policy.**

The policyowner(s) is (are): → ☐ Insured ☐ Other (if a policyowner is not the insured, please provide the information requested below)

When the address of policyowner 2 is different than policyowner 1, we consider that the mailing address corresponds to that of policyowner 1.

Policyowner 1 (if not an insured)	Policyowner 2 (if not an insured)
First and last names	First and last names
Relationship to insured	Relationship to insured
Address	Address
Telephone	Telephone
Principal business or detailed occupation and field of activity (if retired, indicate the last profession and field of activity)	**Principal business or detailed occupation and field of activity** (if retired, indicate the last profession and field of activity)

Upon the death of a policyowner, the rights and interests of such deceased policyowner in the policy shall be transferred to the contingent / successor policyowner designated in this section.

First and last names of contingent / successor policyowner 1	First and last names of contingent / successor policyowner 2
Relationship to insured	Relationship to insured
Date of birth (Y Y Y Y M M D D)	Date of birth (Y Y Y Y M M D D)

B4 – Identity verification

At all times for all product types: The financial security advisor/representative must verify the identity of each **insured**.

How do you verify the identity of each insured (at all times for any type of product)?

Check the box(es) that apply:

☐ **In the physical presence of each person:** using an **authentic (original), valid, unexpired (if applicable) government-issued** photo identification document If you check this box, please indicate below for each person, the identity document being examined, the number it has, its expiry date (if applicable) and the jurisdiction where it was issued. If the "Other document with photo that qualifies under the Act" selection was checked below, please specify the type of document being verified. In Quebec, it is forbidden to ask the client for a health insurance card, but you can accept it if the client offers it to you. Ontario, Manitoba, Nova Scotia and Prince Edward Island prohibit the use of a health card for identification purposes.

☐ **Using the dual process** (if verification done remotely or if an invalid ID is insecure): using two legible, valid and up-to-date documents from two different, independent and reliable sources. → **If you check this box, the Dual Process Method for Identity Verification – Individual – Financial Security Advisor/Representative (FRA1913A) Attestation form is mandatory**.

Insured 1	Insured 2
Name of the insured (as appearing on the document)	Name of the insured (as appearing on the document)
☐ Driver's licence ☐ Passport ☐ Citizenship card with photo	☐ Driver's licence ☐ Passport ☐ Citizenship card with photo
☐ Other photo identification document admissible by Law (specify):	☐ Other photo identification document admissible by Law (specify):
Document number / Jurisdiction	Document number / Jurisdiction
Y Y Y Y M M D D Document expiration date	Y Y Y Y M M D D Document expiration date

Fill out section Identity *Verification for each policyowner*, if not the insured (applicable for Universal Life insurance)

Policyowner 1	Policyowner 2
Name of the policyowner (as appearing on the document)	Name of the policyowner (as appearing on the document)
The policyowner must be a canadian resident	The policyowner must be a canadian resident
☐ Driver's licence ☐ Passport ☐ Citizenship card with photo	☐ Driver's licence ☐ Passport ☐ Citizenship card with photo
☐ Other photo identification document admissible by Law (specify):	☐ Other photo identification document admissible by Law (specify):
Document number / Jurisdiction	Document number / Jurisdiction
Y Y Y Y M M D D Document expiration date	Y Y Y Y M M D D Document expiration date

B5 – Beneficiary(ies) - life insurance

- Indicate the first and last name of the person who will receive the amounts when they become payable under the coverage chosen. In the absence of a beneficiary designation, the amounts will be payable to the owner(s) or their estate(s), as the case may be.
- **If more than one beneficiary is named, the percentage distribution of the shares must be equal to 100%.** If the percentage allocation is not provided, the amounts payable will be divided equally among the eligible surviving beneficiaries.
- Beneficiary designations are revocable unless otherwise specified. In Quebec, however, if the spouse to whom the owner is married or in a civil union is designated as a beneficiary, the designation is irrevocable, unless the spouse has been expressly designated on a revocable basis.
- If the beneficiary predeceased the person to be insured, the amounts provided for will be payable to the contingent beneficiary upon the death of the person to be insured.
- In Quebec, the surviving parent is always the child's guardian, unless otherwise specified in a court judgment.
- If minor children are irrevocably designated, we must obtain a court order or wait until the age of majority before making any requests for changes to the contract, such as partial withdrawals, loans, redemptions, and other related changes.

Proposed insured 1

Beneficiary(ies) for life insurance

	First name	Last name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Check one Irrevocable	Share % Total 100%
1				☐	☐	
2				☐	☐	
3				☐	☐	

Contingent(s) beneficiary(ies)

- In case of death of the beneficiary(ies) designated above, the percentage must be equivalent.

	First name	Last name	Relationship to the proposed (in Quebec, relationship to the policyholder)	Check one Revocable	Check one Irrevocable
1				☐	☐
2				☐	☐
3				☐	☐

Trustee for a minor beneficiary (not applicable in Quebec)

- When a minor is designated as beneficiary, it is suggested that a trust be constituted for claims purposes (not applicable in Quebec).
- If a trust is constituted, complete the information below.

First name of minor beneficiary	Last name of minor beneficiary	Last and first name of trustee	Relationship to the proposed

C – Insurance products

C1 – Simplified Life Insurance

- Specify coverage and face amount.

	Face amount
☐ Simplified Whole Life	$
☐ Simplified Term Life 10	$
☐ Simplified Term Life 20	$

C2 – Guaranteed Issue Life Insurance

	Face amount
☐ Guaranteed Issue Whole Life	$

D – Payment of premiums

D1 – First premium payment

Amount of the first premium payment (amount paid with this application) or of the premium for the request of reinstatement: $ _____

- The payment of the first premium by pre-authorized debit will be withdrawn from the bank account indicated in Section L as shown with the specimen joined with this application.

☐ **Pre-authorized debits** (payment frequency at Section D3 and withdrawal at issue date).

D2 – Payment of premiums

Total of annual premiums: $ _____

Monthly premium, if applicable: $ _____

D3 – Payment frequency

☐ Annual (cheque)

☐ Annual (pre-authorized debits)

☐ Monthly (pre-authorized debits)

- If left blank, the payment frequency will be monthly.
- For pre-authorized debits, complete Section L.

D4 – Day of withdrawal

☐ Day of withdrawal at issue date

OR

☐ Specify the day: _____

- If left blank, the day of withdrawal will be the policy issue date.
- If the day of withdrawal specified is the 29th, 30th or 31st, the day of withdrawal will be the 28th.

E – Insurance in force (Section E must be completed by the insured at all times)

1. Is this application replacing an inforce policy? ☐ NO ☐ YES

2. Do you have any existing individual life insurance? ☐ NO ☐ YES

   If yes, provide the total amount: $ _____

   Please note that the total new and existing individual life insurance amount must not exceed $5,000,000.

3. Do you have any existing Simplified Life Insurance with Beneva? ☐ NO ☐ YES

   If yes, provide the total amount: $ _____

   Please note that the total new and existing Simplified Life Insurance amount with Beneva must not exceed:
   - $500,000 for insureds aged 18 to 50
   - $249,999 for insureds aged 51 to 60
   - $99,999 for insureds aged 61 to 80

4. Do you have any existing Guaranteed Issue Life Insurance with Beneva? ☐ NO ☐ YES

   If yes, provide the total amount: $ _____

   Please note that the total new and existing Guaranteed Issue Life Insurance amount with Beneva must not exceed:
   - $50,000 for insureds aged 18 to 70
   - $25,000 for insureds aged 71 to 80

F – Purpose of insurance

F1 – Personal insurance

☐ Income / Loan protection ☐ Estate conservation ☐ Charitable donations

G – General questions

	Insured	
	Yes	No
1. a) Are you a Canadian citizen or a permanent resident?	☐	☐
b) Do you currently live in Canada?	☐	☐
2. In the past 12 months, have you had an insurance application declined or postponed?	☐	☐

If you are applying for a Guaranteed Issue Life Insurance product, please answer the question below and then proceed to Section K. For a Simplified Life Insurance product, proceed to Section H.

3. Has a physician informed you that you have less than 2 years to live? ☐ Yes ☐ No

H – Medical questions

If you are applying for a Simplified Life Insurance product, please answer the questions below. For a Guaranteed Issue Life Insurance product, proceed to Sections K, L and M. **For any "Yes" responses, please also answer the sub-questions.**	Insured Yes	 No
1. Are you currently confined to a wheelchair (that is, do you use a wheelchair for most of your moves on a weekly basis), bedridden (with the exception of pregnant women), hospitalized or do you need full-time care?	☐	☐
2. **Have you ever** had symptoms or been diagnosed with, received treatment, or consulted a physician for any of the following conditions:		
a) Cerebrovascular accident (CVA) or transient ischemic attack (TIA)? If yes, please answer the sub-questions.	☐	☐
i. Are you 60 years of age or less?	☐	☐
ii. Have you had more than one incident?	☐	☐
iii. Did your CVA or TIA occur less than 8 years ago?	☐	☐
b) Heart attack, heart or coronary artery surgery, chest pain (angina), arrhythmia or any other disorder of the heart or blood vessels?	☐	☐
c) Cancer or malignant tumour of the thyroid? If yes, please answer the sub-questions.	☐	☐
i. Were you diagnosed in the last 10 years?	☐	☐
ii. Did you have metastases and/or chemotherapy treatment?	☐	☐
d) Cancer or malignant tumour other than thyroid cancer and basal cell carcinoma?	☐	☐
e) Type 1 diabetes (insulin-dependent)?	☐	☐
f) Type 2 diabetes? If yes, please answer the sub-questions.	☐	☐
i. Are you under 41 years old?	☐	☐
ii. Were you diagnosed over 15 years ago?	☐	☐
iii. How often do you have follow-ups with your physician for your diabetes: ☐ Less than once per year ☐ Once per year ☐ 2 times per year ☐ 3 times per year ☐ 4 times or more per year		
iv. Has your diabetes medication been changed or increased in the last 6 months?	☐	☐
v. Do you have complications, such as protein in the urine, neuromotor disorders, retinopathy, peripheral vascular disease?	☐	☐
g) i. Hepatitis B or C, cirrhosis, liver failure, chronic pancreatitis?	☐	☐
ii. renal failure, polycystic kidney disease, any other chronic kidney disease?	☐	☐
h) Anemia (other than an iron deficiency diagnosed as benign, treated and stable) or other blood disorder causing recurring embolisms, phlebitis and thrombosis?	☐	☐
i) Schizophrenia, bipolar disorder, psychosis, suicide attempt or hospitalization for any psychological disorder?	☐	☐
j) Systemic lupus, muscular dystrophy, Alzheimer's disease, Parkinson's disease, memory loss, loss of balance, multiple sclerosis, amyotrophic lateral sclerosis (ALS) or any other neurological disorder (excluding migraines investigated by a physician)?	☐	☐
k) HIV test with positive results?	☐	☐
l) Ulcerative colitis or Crohn's disease? If yes, please answer the sub-questions.	☐	☐
i. Were you diagnosed in the past year?	☐	☐
ii. In the last 5 years, have you had more than one attack or flare-up per year?	☐	☐

H – Medical questions (continued)

	Insured	
	Yes	No
3. **In the last 3 years**, have you had symptoms or been diagnosed with, received treatment, or consulted a physician for a respiratory or pulmonary disorder (other than asthma, cold, flu or bronchitis, treated sleep apnea, pneumonia)?	☐	☐
4. **In the last 12 months**, have you been informed of an abnormal result on one of the following tests:		
a) Imaging including ultrasound	☐	☐
b) Mammography or any other breast imaging test	☐	☐
c) EKG (electrocardiogram)	☐	☐
d) Biopsy or pathology report results	☐	☐
5. **In the last 2 years**, have you been informed of an abnormal result on one of the following tests:		
a) Chest x-ray or pulmonary scan	☐	☐
b) MRI or tomography (CT scan)	☐	☐
c) Echocardiogram	☐	☐
d) PSA (prostate specific antigen)	☐	☐
6. **In the last 12 months**, have you been absent from work for more than 1 month for a psychological disorder or was your medication for a psychological disorder increased?	☐	☐
7. Have you consulted a physician for a disease or disorder that has not yet been diagnosed or for which the tests are ongoing or incomplete? Are you waiting on an investigation, result or operation?	☐	☐
8. Have you received an abnormal test result, but have not yet consulted a physician?	☐	☐
9. Do you have symptoms or health problems for which you have not yet consulted a physician, such as: breast mass or lump, shortness of breath, chest pain, unexplained weight loss, dizziness, loss of memory or balance, numbness, difficulty passing urine, blood in urine, rectal bleeding or any other problem not mentioned above?	☐	☐
10. Have any members of your family, including father, mother, brother or sister, had familial adenomatous polyposis (or Gardner syndrome), Lynch syndrome, Huntington's chorea or polycystic kidney disease?	☐	☐

I – Questions about lifestyle

	Insured	
	Yes	No
1. **Have you ever** received counselling, treatment or been advised to reduce your consumption or to undergo treatment for your alcohol or drug use?	☐	☐
2. **In the last 10 years**, have you been charged with or been convicted of a criminal offence or are you currently on probation?	☐	☐
3. Is your driver's licence suspended at the moment?	☐	☐
4. **Have you ever** been charged **more than once** for impaired driving?	☐	☐
5. **In the last 2 years**, have you received more than 3 driving offences?	☐	☐
6. Does your profession fall under one of the following categories? • Journalism and photojournalism (international assignments) • Asbestos worker • Professional athlete • Military currently deployed or on order to be deployed • Commercial aviation (other than pilot for a major airline) • Worker in a bar/nightclub – striptease, escort	☐	☐
7. **In the last 2 years:**		
a) have you flown as a private pilot or student pilot?	☐	☐
b) gone scuba diving deeper than 100 ft, gone parachuting (other than a single tandem jump) or hang gliding, participated in motor vehicle racing, been mountain climbing (with the exception of indoor climbing), out of bounds skiing or snowboarding including by helicopter or by snowcat, off-trail snowmobiling or done any other extreme sport?	☐	☐

I – Questions about lifestyle (continued)

	Insured	
	Yes	No
8. **In the next 12 months**, do you intend to travel or live outside of Canada:		
a) for more than six (6) months?	☐	☐
b) in a destination other than the following countries: the Caribbean/Antilles as part of an all-inclusive vacation, United States, Mexico, European Union countries, United Kingdom, Hong Kong, China, Japan, Australia, New Zealand, India?	☐	☐

9. What is your tobacco use?

Cigarettes, cigars, cigarillos, electronic cigarettes/vaping, nicotine substitutes, or any other product containing tobacco or nicotine

I used
- ☐ In the last month
- ☐ In the last 3 months
- ☐ In the last 6 months
- ☐ In the last 12 months
- ☐ Between 1 and 5 years ago
- ☐ Over 5 years ago
- ☐ Never

My typical usage is/was
- ☐ 30 or more per day
- ☐ 20-29 per day
- ☐ 10-19 per day
- ☐ 1-9 per day
- ☐ Less than 7 per week
- ☐ Less than once per week
- ☐ Less than once per month

10. What is your marijuana use?

I used
- ☐ In the last month
- ☐ In the last 3 months
- ☐ In the last 6 months
- ☐ In the last 12 months
- ☐ Between 1 and 5 years ago
- ☐ Over 5 years ago
- ☐ Never

My typical usage is/was
- ☐ More than 2 times per day
- ☐ More than 1 time per day
- ☐ Once per day
- ☐ Less than 7 times per week
- ☐ Less than 3 times per week
- ☐ Less than once per week
- ☐ Less than once per month

11. Tell us about your drug use:

Heroin, cocaine, hallucinogens or any other drug not prescribed by a physician, except for over-the-counter medication

I used
- ☐ In the last month
- ☐ In the last 3 months
- ☐ In the last 6 months
- ☐ In the last 12 months
- ☐ Between 1 and 6 years ago
- ☐ Over 6 years ago
- ☐ Never

12. On average, how many of these alcoholic beverages do you drink per week:

	I drink per week
Beer (341 ml)	
Wine (1 glass = 142 ml)	
Liquor/Spirits (1.5 oz)	

J – Question about height and weight

1. What is your height: _____ ☐ ft ☐ m
2. What is your weight: _____ ☐ lbs ☐ kg

K – Notice to proposed insured(s) and policyowner(s)

Notice regarding the investigative consumer report

For the insurance applications to be processed, all insurance companies, including Beneva Inc., may ask for a personal investigative consumer report in order to obtain information through personal interviews with neighbours, friends, associates and other designated people. The investigative consumer report may concern your reputation, lifestyle and finances. A representative of a consumer reporting agency may visit you or call you.

Notice regarding the MIB, LLC

Certain information must be collected when an insurer receives an application for insurance, and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

To help ensure fair underwriting for all insureds, most insurance companies, including Beneva Inc. (Beneva), work with an organization called the MIB, LLC (MIB).

Information regarding your insurability will be treated as confidential. Beneva or its reinsurers may, however, make a brief report thereon to MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing Canadadisclosure@mib.com or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Your information may be transmitted and stored outside of Canada and governed by the laws of foreign countries or states.

Beneva or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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.

For the sole use of Beneva financial advisors (BFA)

Consent to receive personalized product offers and advice on products and services (optional)

I consent to the necessary collection, use and disclosure of my personal information by Beneva to service providers as well as websites and applications belonging to third parties to receive personalized offers and advice on products or services.

I understand that I may withdraw my consent by calling 1 844 781-0860 or visiting Beneva.ca

☐ **Policyowner 1** ☐ **Policyowner 2**

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.

L – Declarations

The undersigned:

1. Agree that an additional questionnaire on lifestyle and medical history may be completed during the meeting with the financial security advisor / representative, during a personal meeting or a RECORDED telephone conversation with a paramedical company or another authorized person representing or acting for Beneva Inc. The undersigned agree that the additional questionnaire shall be deemed to form part of this application and that the information it contains shall be used to draw up a contract with Beneva Inc. The undersigned further agree to review such information upon receipt of the contract and to inform Beneva Inc. forthwith if it contains any information that is false, inaccurate or incomplete.
2. Agree that all information that they divulged during a RECORDED telephone interview to a paramedical company or another authorized person representing or acting for Beneva Inc., including but not limited to, their medical history and state of health, is deemed to form part of this application and that this information shall be used to draw up a contract with Beneva Inc. The undersigned agree that any recording, transcription or other notation of such information by Beneva Inc. or on behalf of Beneva Inc. shall be considered to be accurate, complete and binding as if given in writing to you.
3. Agree that, if the information recorded is inaccurate or incomplete (including, without limitation, the information provided to justify the rates applied for non-smokers with respect to an insured under the terms of the requested contract), the contract shall be void with respect to such insured.
4. Agree that, if a temporary insurance agreement has been drawn up for life insurance, the amount payable under the aforesaid temporary insurance agreement and such other temporary insurance agreement as may be drawn up by Beneva Inc. for each insured life shall be limited to the lesser of $500,000 or the total face amount requested in the insurance applications.
5. Agree that, if a conditional insurance policy is drawn up for critical illness insurance, the amount payable shall be the lesser of the face amount requested in this insurance application or $500,000 less all other face amounts under any critical illness insurance pending or in effect with Beneva Inc.
6. Agree that this application, as well as the attached temporary insurance agreement relating to life insurance and the attached conditional insurance policy relating to critical illness insurance, if any, are subject to the laws of the province where the policyowner resides when the policy is issued, subject to applicable laws.
7. Agree that, under the Term Plus product, the benefit payable in the event of a total disability, when the disability rider without guarantee – Proof of loan upon claim has been selected, or, when the monthly indemnity is more than $2,000, shall be based on the total amount of eligible monthly payments for all eligible loans in effect at the time of total disability, regardless of the monthly amount that is underwritten in the present application. The benefit payable shall not exceed the monthly amount that is underwritten in the present application, subject to the terms of the contract. When the disability rider without guarantee – Proof of loan upon claim has been selected, if there is no eligible monthly payment in effect at the time of total disability, the undersigned agree that the liability of Beneva Inc. shall be limited to the refund of premiums received since the loan or loans were discharged, on the understanding that this refund shall not exceed a period of eighteen (18) months prior to the date the total disability benefit was requested.
8. Agree that they have received the advisor's explanations concerning the possibility of a tax rule change that certain changes, which require evidence of insurability, may cause, if any. As such, the entire policy could be subject to the tax rules in effect as of January 1st 2017, if it is not already the case.
9. Declare having been made aware that Beneva may gather personal information using technology that has identification, localization and profiling features, which are necessary for evaluating applicants. This is the case for the electronic application, which is used to assess a person's risk profile in order to provide the best possible premium. The undersigned agree that submitting an application initiates this process.
10. Declare having been made aware that Beneva may use their personal information to make entirely automated decisions (i.e. no human intervention). For example, in the case of an electronic application, an automated decision may be made in an effort to accelerate the underwriting process, including premium calculation and risk selection.
11. Declare that the information provided in this application with respect to universal life insurance (if applicable) concerning their contact information, identification information, occupation (including job title, field of activity, name of employer and employment status) and the purpose of insurance, is accurate, complete and has been correctly indicated, and they agree to promptly notify their financial security advisor/representative of any change in this information. The financial security advisor/representative will then forward the updated information to Beneva Inc. without delay.
12. Declare that the information provided in the Declaration of Tax Residence section is correct and complete and agree to provide Beneva Inc. with a new tax residence declaration within 30 days of any change in circumstances that causes the information on this form to become incomplete or inaccurate.
13. Declare that the aforesaid statements are true and complete, have been correctly recorded and form part of the insurance application 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.
14. Declare having been made aware of the personal information protection notice as well as of all other notices sent to the applicant(s) and the owner(s) as well as having accepted the terms and conditions herein.

_____ This _____ day of _____ of year _____

Signed at (city and province) Date

X _____

Signature of insured 1

X _____

Signature of policyowner 1 – only necessary if not an insured

X _____

Signature of policyowner 2 – only necessary if not an insured

M – Authorizations

Your authorizations are necessary in order to provide and administer your products and services.

1. Authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.
2. Authorize Beneva Inc. and its reinsurers to gather, use and provide, for the purposes indicated in the protection of personal information notice, to all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history and lifestyle habits. This authorization is valid for the specific period required to process the request. A photocopy or digital version of this authorization is as valid as the original.
3. Authorize Beneva Inc. and its reinsurers to gather personal information from a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is valid for the specific period required to process the request.
4. Authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and consents required to obtain the necessary proof and process the death benefit claim.

Insured

I acknowledge having read the 4 authorizations above-mentionned and agree to them.

Name of insured (please print)	X Signature of insured	Y Y Y Y M M D D Date

N – 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 or annually 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 depending on the product chosen, a monthly payment will result in a higher annualized premium.
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 (or each year) 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

Important notice: In the absence of completing the information below and a specimen cheque, Beneva Inc. will withdraw the pre-authorized debits from the bank account of the cheque provided with this application.

Name of financial institution

Address, city, province and postal code of branch

Branch | Financial institution number | Account number

Authorization

Is the account joint? ☐ **Yes** ☐ **No**

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

O – Financial security advisor's / representative's report

1. Source

   ☐ From insured ☐ Referred ☐ Associate ☐ Life customer ☐ P&C customer ☐ Other (specify): _____

2. Relationship with insured

   ☐ Personal friend ☐ Relative (specify): _____ ☐ Other (specify): _____

   How long have you known the insured? Y Y Y Y M M D D

3. Do you have any doubts about the insurability of the insured?

   ☐ Yes ☐ No If yes, please specify: _____

4. Are you personally aware of the habits of the insured?

   ☐ Yes ☐ No If yes, please give details: _____

5. Which language(s) has (have) been used to complete the application? _____

6. Has the individual told you that they understood the language used to complete the application?

   ☐ Yes ☐ No

7. If a language other than English has been used, please name the person who explained the application to the individual to be insured. The person cannot be the beneficiary or a family member of the person to be insured.

   _____

O1 – Financial security advisor / representative certification

I confirm that I have provided an Advisor Disclosure Statement to the policyowner(s) disclosing the following:

- the name of the company or companies I represent at this moment;
- that I will receive compensation such as commissions for the sale of life 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.

If I am not the service advisor for this policy, I declare that I have informed the policyowner(s) of that fact and of the identity of his/her (their) service advisor as it appears in Section M2.

_____ _____

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

X _____ Y Y Y Y M M D D

Signature of financial security advisor / representative Date

O2 – Information about financial security advisor / representative

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

Name of service advisor (in capital letters) | Agency | Code of financial security advisor / representative

Share % (multiples of 5%) | Telephone number

Name of other advisor sharing commission (if applicable) (in capital letters) | Agency | Code of financial security advisor / representative

Share % (multiples of 5%) | Telephone number

Name of other advisor sharing commission (if applicable) (in capital letters) | Agency | Code of financial security advisor / representative

Share % (multiples of 5%) | Telephone number

☐ **I do not have an advisor's code with Beneva Inc. This is my first application.**

Comments and details from financial security advisor / representative