La Capitale
Financial Security

Safe Driver
Application for Insurance

INSTRUCTIONS – Complete this application form only for Safe Driver with or without Return of Premium rider. For Safe Driver with the All Accident rider, do not use this form. Complete the Application for Insurance (ZAH-260).

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

☐ NEW APPLICATION OR ☐ PLAN CHANGE / ☐ REINSTATEMENT /
☐ INCREASE TO POLICY NO. _____

Contract No. Leave this blank if this is a new application form

1 POLICYHOLDER/INSURED'S INFORMATION

Language of correspondence ☐ English ☐ French	☐ Male ☐ Female	Last name	First name	Middle name
Last name at birth (if different)		Country of birth	Age[1]	Date of birth[1] Month / Day / Year
Address (No., street)				Apt.
City	Province	Postal code	Home tel.	
☐ Cell tel. ☐ Work tel.	(extension)	Email		
Occupation		Height _____ cm / _____ ft. _____ in.	Weight _____ kg / _____ lbs.	
Association: ☐ Yes ☐ No – If Yes, name of the association: _____				
Status: ☐ Canadian citizen ☐ Permanent resident ☐ Temporary resident ☐ Other: _____				

2 VERIFICATION OF POLICYHOLDER/INSURED'S IDENTITY

ID (Original documents only) ☐ Passport ☐ Driver's licence ☐ Health Insurance card (except Ont., Man., P.E.I.)[2] ☐ Other photo ID issued by a federal or provincial government: _____	Document No.
Expiry date (if available) Year / Month; Jurisdiction of issue	Province or country of issue

3 ELIGIBILITY

To be eligible for Safe Driver, the policyholder/insured needs to be able to answer *NO* to questions 1, 2, 3 and 4.

1.	In the last 3 years, have you been charged with impaired driving under the Criminal code or been charged with careless or dangerous driving?	☐ Yes ☐ No
2.	Do you currently work as an ambulance, city bus, taxi, limo, or tow truck driver? Or are you a paramedic, firefighter, or a police officer?	☐ Yes ☐ No
3.	Are you currently disabled or receiving disability benefits?	☐ Yes ☐ No
4.	Do you engage in competition, racing or speed contests?	☐ Yes ☐ No
5.	Do you already have Safe Driver coverage or do you have an application pending for such coverage?	☐ Yes ☐ No

Note 1: The policyholder/insured must be age 16 to 80 inclusive.
Note 2: In Quebec, the health insurance card can not be required for identification, but if the policyholder/insured chooses to present it, it is accepted.

Please initial any changes made.

4 CHOICE OF COVERAGE

Coverage	Monthly benefit (maximum of $1,600)	Annual premium		Policy or rider service premiums[3]		Annual premium including service premiums (A + B)	
☐ Safe Driver plan	$	$	**A** +	$	**B** =	$	**C**
☐ Return Of Premium Rider[4]		$	**D** +	$	**E** =	$	**F**
				Provincial Sales Tax (PST) if applicable	+	$	**G**
				Total annual payment[5] (C + F + G)	=	$	

Note 3: Policy and rider service premiums are charged on an annual basis.
Note 4: Policy service premiums, rider service premiums, provincial sales tax, if applicable, and any fees charged with regard to a method of payment option will not be reimbursed.
Note 5: This amount includes the policy and rider service premiums and any applicable taxes (e.g., PST) and fees.

5 BENEFICIARY INFORMATION (for the Accidental Death benefit)

A beneficiary is not designated: If a beneficiary is not designated, any benefits will be paid to the policyholder/insured's estate.

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 named. 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). Any amount payable to a beneficiary who has reached the age of majority is payable directly to this person. 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.

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

6 PAYMENT

6.1 SELECT PAYMENT METHOD

☐ Annual ☐ Semi-annual ☐ Preauthorized debit (PAD) Complete Section 8.

6.2 SELECT PAYMENT METHOD FOR THE INITIAL PAYMENT

☐ Cheque or money order attached to this application form: $ _____ Must be made out to La Capitale Financial Security Insurance Company.

☐ Credit card Complete Section 7.

7 PAYMENT OF THE INITIAL PAYMENT BY CREDIT CARD

7.1 NOTICE

Section 7.2 below, which only contains information regarding the credit card used as the payment method for the initial payment, will be voluntarily deleted from this document prior to being filed in the Insurer's records. This is done for purposes of confidentiality and compliance with applicable laws and rules. The deletion of Section 7.2 does not constitute an alteration of this document of any kind whatsoever. The parties therefore agree that despite the deletion of Section 7.2, this document represents the entire and complete agreement between the parties with respect to its subject matter.

Please initial any changes made.

7.2 AUTHORIZATION

☐ Visa
☐ MasterCard
☐ American Express

Credit card number: _____ Expiry date: Month Year

Authorization No. Reserved for the Administration

I authorize the Insurer to charge the initial payment of $_____ to the above-mentioned credit card. Upon receipt of this authorization, the Insurer will request the necessary authorization from the credit card issuer. If such authorization is obtained from the credit card issuer, the credit card will be charged. In the event the premium is increased after my application is reviewed, I authorize the Insurer to charge the additional amount to the credit card. In the event the initial premium is decreased, the Insurer will reimburse any excess by cheque.

Credit cardholder's signature	Credit cardholder's name	Date

Please initial any changes made.

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8 PREAUTHORIZED DEBIT (PAD) AGREEMENT

PREMIUM PAYOR'S INFORMATION

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

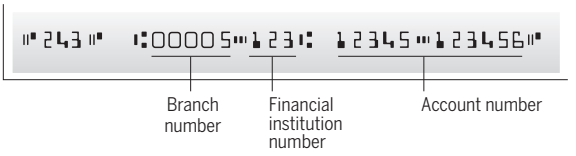
_____ _____
Address (No., street, apt., city, province) Postal code

_____ _____ Date of birth: _____ _____ _____
Area code Tel. Year Month Day

☐ Business: _____ _____
Company name Area code 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

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 or authorized signatory 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

9 DECLARATIONS AND AUTHORIZATIONS

I acknowledge that the answers given in this application are true and complete. I hereby authorize the Insurer or its reinsurers, for underwriting, administration and claims adjudication purposes only: a) to gather only that information necessary from any person or organization that has personal information relating to me or any family member to be insured, including other insurers, physicians, medical institutions, provincial or territorial WCB, WSIB or WHSCC, other government organizations, the MIB, Inc., investigation and consumer reporting agencies, and all persons likely to have personal information relevant to the object of the file; b) to disclose to these same persons and organizations only the necessary personal information relating to me to allow them to collect the required information; c) to share such information as is necessary for the purposes described above with the advisor and agency of record of the policy issued in connection with this application; and d) to make a brief report of my personal health information to MIB, Inc. I understand and agree that: a) the Insurer may provide access to my personal information to service providers located in jurisdictions outside Canada who provide the Insurer with products and services, including but not limited to, information technology, data storage, claims adjudication and reinsurance services; and b) I can obtain access to the Insurer's policy on personal information protection at www.lacapitaleFS.com under "Privacy Policy". A photocopy of this authorization is considered as valid as the original. This authorization is valid for the period required to achieve the purpose for which it was requested. I acknowledge receipt of notice regarding the MIB, Inc. I acknowledge that the Insurer may refuse to consider my application for insurance if I do not comply completely with this authorization.

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

✗ _____
Policyholder/insured's signature

Please initial any changes made.

CONDITIONAL RECEIPT

APPLICATION NO.: _____ **PLAN SELECTED:** _____

If you qualify, policy/rider may take up to six weeks to issue. If acknowledgement is not received within 30 days, contact us at (refer to application No.):
LA CAPITALE FINANCIAL SECURITY INSURANCE COMPANY 1 800 268-2835 (English) or 1 800 363-8011 (French)

RECEIVED FROM: _____ **Date:** _____ **. This receipt is issued for $** _____

for an application for the insurance described in the policy/rider applied for. If all the following conditions are met and the Insurer issues a policy/rider to the policyholder/insured, such policy/rider will cover the policyholder/insured in accordance with its provisions, limitations and exceptions, for losses on or after the date of application:
1. All the information given by the policyholder/insured in the insurance application or any supplementary form must be accurate and complete.
2. The Insurer must find the policyholder/insured qualified for the plan and amount applied for in accordance with its normal and customary underwriting standards and practices.
3. The payment for which this receipt is issued must be one complete payment, according to the Insurer's underwriting rules, for the payment method selected in the application.

IN THE EVENT THE APPLICATION IS REJECTED, THE ABOVE AMOUNT WILL BE REFUNDED IN FULL BY THE INSURER.

TOTAL ANNUAL PAYMENT $_____ Cheque or money order payable to La Capitale Financial Security Insurance Company must accompany the application or Authorization for the Initial Payment by Credit Card must be duly completed and signed.

Licensed agent or advisor: _____

Please initial any changes made.

10 AGENT OR ADVISOR'S REPORT

IF DELIVERY HAS NO REQUIREMENTS: ☐ Mail policy to policyholder/insured ☐ Mail policy to office

10.1 AGENT OR ADVISOR'S INFORMATION

Agent or Advisor's name	Agent or Advisor's code	Sales/Regional office/Mail code

10.2 COMMISSION SPLIT

Agent or Advisor's name	Agent or Advisor's code	Split
		%
		%
		%
		%

10.3 AGENT OR ADVISOR'S DECLARATION

I hereby certify that I have truly and accurately recorded on this application the information supplied by the policyholder/insured [and spouse and child(ren) if applying]. I certify that I have disclosed the names of the companies I represent, the fact that I am compensated by commission on the sale of insurance products and that I may receive additional compensation in the form of bonuses, convention participation or other incentives, as well as disclosing as any potential conflicts of interest with regard to this sale. I certify that I have seen the client in person and that I have seen the client's identification and compared the signature on the identification document with the policyholder/insured's signature on the application.

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

X _____

Agent or Advisor's signature

11 SPECIAL INSTRUCTIONS