

APPLICATION FOR ACCIDENT ONLY INSURANCE

□ NEW APPLICATION or
 □ PLAN CHANGE / □ REINSTATEMENT / □ INCREASE TO POLICY N° ____

CENERAL INFORMATION

GENERAL INFORMATION											
Language of correspondance: Engli	sh 🗆 French										
Last name (Policyholder/insured)			First	name							
Middle name	Last n	ame at bi	irth (if diff	erent)			S.I.N.		1 I		1
Address (No., street)							Apt.	Pos	stal code	I	
City		Province	e Age	Sex	e 🗆 Female	Coun	try of birth				
Date of birth Home	tel.			Busin	ess tel.				Extensi	on	
Cell tel.	Best time to ca		Best tel. □ Home [En	nail addres:	S			
Emergency contact name	Emergency con					on: 🗆 No	o □ Yes – If	so, nam	ne of the	associa	ation:
Identification type (photo ID issued by a federa	al or provincial gove	ernment):			F	Province	or country o	of issue:			
Document No.:	Jurisdio	ction of iss	sue:				Expiry da	te (if ava	ilable):	MIN	YY
Status: 🗆 Canadian citizen 🗆 Perman											
SECTION 1 - PRODUCT SEI	LECTION I h	ereby a	pply for	the Ace	cident On	ly cove	rages I h	ave sel	ected b	below:	
Policy/Rider Applied For: Policy or	Rider Elim.	Period	Bei	nefit Am	ount	Po Se	olicy or Ride ervice Prem	er niums ¹			remium vice Premiums
-			\$			\$_				\$	
-			\$								
□ Policy □ Policy □ POlicy □ ROP-PVR (Return of Premium Rider ²)	Rider		\$			\$_ \$					
Note 1: Policy and Rider Service Premiums are charged	on an annual basis.						ovincial Sales	Tax (PST)			
Note 2: Policy Service Premiums, Rider Service Premium option will not be reimbursed. Note 3: This amount includes the Policy and Rider Servi	ms and any fees charge	-				тс	applicable DTAL ANNU AYMENT ³	AL	:	₽ \$	
SECTION 2 - INCOME AND	OCCUPATI	ON									
Part A (Self-Employed) Occupatio	n and exact duti	ies:									
Type of business: Sole proprietor Partne	ership 🗌 Corporati	on If ow	ner, perce	ntage of	ownership: _		Home ba	sed busi	ness? 🗆	Yes 🗆	No
Company name:							Date busir	ness star	rted:		
Hours per week worked:	Years ir	n industry	:			Numbe	r of employ	ees:			
Have you filed for bankruptcy in the last 3 year	ars? 🗆 Yes 🗆 N	o If Ye	es, when w	as your b	ankruptcy c	discharge	ed? Date: _				
What estimated percentage of work is:	abour % Adm	ninistrative	%	Supervisor	y% (Client Rela	ation/Market	ing q	% Actu	al Drivin	ng %
If less than 12 months earned, indicate number	er of months earne					5) 20	0		20		
					<u>ss</u> income						
			ess all ope et earned		•	=			=		
Part B (Employee) Occupation an	nd exact duties:										
Employer's name, address & phone nu	mber:										
Hours per week worked: Years e					Gross ea	rned an	nual incom	e⁴: \$			
COMPLETED BY: SALES OFF The individual who wrote this application must	t be listed below a	s either Ag	gent/Advis		or 4 and pr	ovide his	s/her own a	gent coc	de.		
Sales/Regional Office/Mail Code:									0		
Agent/advisor 1 name:					visor code: <u>-</u>						
Agent/advisor 2 name: Agent/advisor 3 name:					visor code: <u>-</u> visor code: <u>-</u>						
Agent/advisor 4 name:					visor code: <u>-</u> visor code: <u>-</u>						
Complete when partnership, business or fami	ly applications are	being sub	omitted to	gether:	name						
Note 4: Investment income, dividends, rental, pension, em											
ZAH-261 07-2019			1		La	Capitale F	Financial Sec	urity Insu	irance Co	mpany ((the Insure



SECTION 3 – COMPLETE IN ALL CASES

o	IN. C	or	_ cm	Pr	esent	t Weight:		lt	os. or		kg	
1. Are you currently receiving disability benefits, including but not limited to worker's compensation, due to an accident, injury, sickness or disability?												Yes No
2. Within the last 3 years:					4. Do y	/ou engage in	competit	ive racir	ng or spe	ed contes	sts (limited to vehicles)?	
 a) have you lost more than 10 continuous days of work or been hospitalized as a result of sickness or injury? 					 5. a) Are you now insured or are applications pending for Life, Accident or Sickness Insurance (including group or union coverages) or have you ever been insured by La Capitale Financial Security Insurance Company (formerly known as Penncorp Life Insurance Company)?							
b) have you received benefits from any source?												
c) have you been charged with impaired driving under the Criminal Code, been charged with careless or dangerous												
• •												
ou been incarcerated?												
						(If No, provide details.)						
Is Name of company	Year of	Life Insu	rance			Accidental	Benefit	Period	Elimi	nation	Pending, Retaining or Re	placing
	issue	Plan	Amt	Веп	ient	Death	Acc.	Sick.	Acc.	Sick.		
th second sin sin sin sin sin sin sin sin	I limited to worker's compent, injury, sickness or disab the last 3 years: you lost more than 10 con- een hospitalized as a result you received benefits from you been charged with imp inal Code, been charged with ng, or had your driver's lice you been incarcerated? you had 3 or more moving alls Name of company	Iimited to worker's compensation, dunt, injury, sickness or disability? the last 3 years: you lost more than 10 continuous date on hospitalized as a result of sickness you received benefits from any source you been charged with impaired drivining inal Code, been charged with careless on ng, or had your driver's licence susper you been incarcerated? you had 3 or more moving violations? ails Name of company	Iimited to worker's compensation, due to an nt, injury, sickness or disability? the last 3 years: you lost more than 10 continuous days of work een hospitalized as a result of sickness or injury? you received benefits from any source? you been charged with impaired driving under the inal Code, been charged with careless or dangerous ng, or had your driver's licence suspended? you been incarcerated? you had 3 or more moving violations? Life Insur ails Name of company	Imited to worker's compensation, due to an ant, injury, sickness or disability? init, injury, sickness or disability? init, init, in	Imited to worker's compensation, due to an ant, injury, sickness or disability? intervention of the last 3 years: you lost more than 10 continuous days of work een hospitalized as a result of sickness or injury? you been charged with impaired driving under the inal Code, been charged with careless or dangerous ng, or had your driver's licence suspended? you been incarcerated? you had 3 or more moving violations? Life Insurance More marked for the insurance market and the insurance market and the insurance market and the incarcerated for the	Imited to worker's compensation, due to an int, injury, sickness or disability? Imited to worker's compensation, due to an int, injury, sickness or disability? Imited to worker's compensation, due to an int, injury, sickness or disability? 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Imited to worker's company int, injury, sickness or injury? Imited to worker's company int, injury, sickness or injury? Imited to worker's company int, injury, sickness or injury? Imited to worker's company int, injury, sickness or injury? Imited to worker's company int, injury, sickness or injury? Imited to worker's company int, injury, sickness or injury? Imited to worker's company int, injury, injury,	 Ilmited to worker's compensation, due to an int, injury, sickness or disability? the last 3 years: you lost more than 10 continuous days of work een hospitalized as a result of sickness or injury? you been charged with impaired driving under the inal Code, been charged with careless or dangerous ng, or had your driver's licence suspended? you been incarcerated? you been incarcerated? you had 3 or more moving violations? ails Name of company Year of Issue Iss	 Ilmited to worker's compensation, due to an ant, injury, sickness or disability? the last 3 years: you lost more than 10 continuous days of work are hospitalized as a result of sickness or injury? you been charged with impaired driving under the inal Code, been charged with careless or dangerous ng, or had your driver's licence suspended? you been incarcerated? you been incarcerated? you had 3 or more moving violations? ails Name of company Year of Issue Life Insurance Monthly Accidental Death Consulted a physician for alcohor (If Yes, complete Alcohol/Drug, Z 4. Do you engage in competitive racin 5. a) Are you now insured or are ap Sickness Insurance (including been insured by La Capitale F (formerly known as Penncorp (If Yes, provide details in chart b) Are you applying for any othe (If Yes, please provide details in chart for you have a valid driver's licence (If No, provide details.) 	 Ilmited to worker's compensation, due to an nt, injury, sickness or disability? the last 3 years: you lost more than 10 continuous days of work cen hospitalized as a result of sickness or injury? you been charged with impaired driving under the inal Code, been charged with careless or dangerous ng, or had your driver's licence suspended? you been incarcerated? you been incarcerated? you had 3 or more moving violations? If Year of Lissue Life Insurance Monthly Benefit Name of company Year of Lissue Consulted a physician for alcohol/drug u (If Yes, complete Alcohol/Drug, ZL-436 U) Consulted a physician for alcohol/drug u (If Yes, complete Alcohol/Drug, ZL-436 U) Are you now insured or are application Sickness Insurance (including group o) been insured by La Capitale Financial (formerly known as Penncorp Life Insurance (If Yes, please provide details in chart provide details in chart provide details.) 	 Ilmited to worker's compensation, due to an nt, injury, sickness or disability? the last 3 years: you lost more than 10 continuous days of work een hospitalized as a result of sickness or injury? you been charged with impaired driving under the inal Code, been charged with careless or dangerous ng, or had your driver's licence suspended? you been incarcerated? you been incarcerated? you had 3 or more moving violations? year of lissue Life Insurance Monthly Benefit Monthly Benefit 	 Ilmited to worker's compensation, due to an nt, injury, sickness or disability? the last 3 years: you lost more than 10 continuous days of work een hospitalized as a result of sickness or injury? you been charged with impaired driving under the inal Code, been charged with careless or dangerous ng, or had your driver's licence suspended? you been incarcerated? you been incarcerated? you had 3 or more moving violations? you had 3 or more moving violations? If Issue Imited to worker's complete Alcohol/Drug, ZL-436 Usage Questionnaire.) Loo you engage in competitive racing or speed contests (limited to vehicles)? A. Do you engage in competitive racing or speed contests (limited to vehicles)? So a) Are you now insured or are applications pending for Life, Accident or Sickness Insurance (including group or union coverages) or have you ever been insured by La Capitale Financial Security Insurance Company (formerly known as Penncorp Life Insurance Company)? b) Are you applying for any other coverage with La Capitale? c) b) Are you applying for any other coverage with La Capitale? c) b) Are you have a valid driver's licence? c) file Insurance d) file Insurance Monthly Benefit Death

Skip SECTION 4 and proceed to complete the final steps of this application if applying for Accident Only Hospitalization, Safe Driver, Accidental Death, Convalescence or 6 month disability (accident only) less than or equal to \$2,000/month total Insurer coverage.

SECTION 4 - ACCIDENT ONLY DISABILITY	BEN	EFIT SEC	IUN		
Have you lost more than 4.5 kgs (10 lbs.) in the last year? Yes 🗆 No 🗆 If	Yes, num	nber of kgs (lbs.)	lost and reason:		
Name of physician:			Phone number:		
Address:					
Date of last consultation: Reason:			Result:		
 Within the last 10 years: have you received benefits from any source? have you used or do you currently use narcotics, hallucinogens, barbiturates, amphetamines, marijuana, cocaine, heroin or 	Yes No	v. chroni syndro vi. diabet (If Yes,	c pain or fatigue, fibromyalgia ome or sleep apnea? es, elevated sugar in blood or <i>complete Diabetes, ZL-436B</i>		Yes No
 other drugs except as prescribed by a physician?		a) have y hazarc (a) roc gliding	last 3 years: ou engaged or intended to er lous activities such as, but no leo, (b) mountain or rock clin ;, (d) parachuting, (e) compet contests (not limited to vehic	ot limited to nbing, (c) hang itive racing or	
 d) have you ever been treated for or advised for, or had any indication of: disorders of the spine, back, joints (including but not limited to dislocated joints), hips, back pain or sciatica? (If Yes, complete Back Pain and Musculoskeletal, ZL-438 Questionnaire.) 		(If Yes, ZL-436 b) have y any re done y	complete Sport, Amusement 5A Questionnaire.) ou been advised to have any c lated to genetic testing) or su et, or has been completed but	, or Avocation, liagnostic test (other than Irgery which has not been the results not received?	
 ii. arthritis, rheumatism, gout, neuritis, or disorders of the muscles or bones (included but not limited to sprains, tears and pulled muscles or broken bones), or have any deformity or amputation? (If Yes, complete Back Pain and Musculoskeletal, ZL-438 Questionnaire.) 		or disa modifi 3. Have you e diagnosed	ou ever had a life, critical illne bility insurance application d ed or rated with a higher prer ever been treated for, tested p as having an Immune Deficie mmune Deficiency Syndrome ARC) or tested positive for H	eclined, deferred, nium? positive or been ency Disorder,	
 iii. dizziness/fainting, epilepsy, paralysis, dementia, Alzheimer's, Parkinson's or organic brain disease? iv. depression, schizophrenia, other mental or nervous disorder? 		4. Are you cu (If Yes, pro including I	irrently taking any prescribed vide details in the chart provi ist of medications and dosage	l medications?	
If any questions in SECTION 3 or 4 have been answered	d "Yes"	, please prov	ide details below.		
Section Question Details or name of Date Date Details	of treatm	nent and/or	Was recovery complete? If no,	Name and address of at	tending

ii aiiy	questio				iswered res, preuse prov	luc uctuiis below.	
Section number	Question number	Details or name of injury or sickness	Date started	Date recovered	Details of treatment and/or operation (dosage of medication)	Was recovery complete? If no, give details of remaining effects	Name and address of attending physician and/or hospital
ZAH-261	07-2019				2	La Capitale Financial Secu	rity Insurance Company (the Insure
	·						

AUTHORIZATION: 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, without limiting, 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 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.

Signature of policyholder/insured: X

DO NOT DETACH THIS AUTHORIZATION - RETURN TO HEAD OFFICE

Date:

La Capitale Financial Security

The terms "estate", "successors'							
irrevocable unless the policyhold	on to whom the policyholder	/insured is married of	or civilly united, this de	esignation is			
Last name	First name	Date of birth (MM/DD/YYYY)	Relation to policyholder/insured		designation le Irrevocable		
Primary							
Contingent							
SECTION 6 - DECLARA	TION & AGENT/ADVI	SOR STATEMEN	Γ				
DECLARATION – I hereby application is used in reliance upon the writted are my own and are true and comby the Insurer.	en answers to the questions ir	n this application. I agr	ee that the answers rec	orded on this	applica	ation	
Dated at: City	Province		on Month	Day	Year		
Signature of policyholder/insu	red: X		Month	Бау	lear		
AGENT/ADVISOR STATEMI	ENT						
If Delivery Has No Requiremen							
	e on the application.					n the	
Can the policyholder/insured real If "NO" have you fully explained to the application is fully understood Do you have any knowledge of the	he details of the application to d? e policyholder/insured persor	the policyholder/insu	red and are you satisfied	d that tation	Yes I		
Can the policyholder/insured real If "NO" have you fully explained t the application is fully understoo Do you have any knowledge of th that might affect the underwritin	ad, speak and understand he details of the application to d? e policyholder/insured persor g risk?	the policyholder/insun nal habits, health, avoca	red and are you satisfied ations, finances or reput	d that tation	Yes I	No	
Can the policyholder/insured real If "NO" have you fully explained to the application is fully understood Do you have any knowledge of the	ad, speak and understand he details of the application to d? e policyholder/insured persor g risk?	the policyholder/insun nal habits, health, avoca	red and are you satisfied ations, finances or reput	d that tation	Yes I	No	
Can the policyholder/insured real If "NO" have you fully explained to the application is fully understood Do you have any knowledge of the that might affect the underwriting I have given the policyholder/insure Signature of Licensed	ad, speak and understand he details of the application to d?	the policyholder/insur nal habits, health, avoca Client Information No Signature of Trai	red and are you satisfied ations, finances or reput otice	d that tation	Yes I	No	
Can the policyholder/insured real If "NO" have you fully explained to the application is fully understood Do you have any knowledge of the that might affect the underwritin I have given the policyholder/ins	ad, speak and understand he details of the application to d?	the policyholder/insur nal habits, health, avoca Client Information No Signature of Trai	red and are you satisfied ations, finances or reput	d that tation	Yes I	No	

CONDITIONAL RECEIPT APPLICATION NO. PLAN SELECTED 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 # A CAPITALE FINANCIAL SECURITY INSURANCE COMPANY 1800 268-2835 (English) or 1800 363-8011 (French)):
Date This receipt is issued for \$ or 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/ride policyholder/insured, such policy/rider will cover the policyholder/insured in accordance with its provisions, limitations and except or losses on or after the date of application: All the information given by the policyholder/insured in the insurance application or any supplementary form must be accurate and complete. The Insurer must find the policyholder/insured qualified for the plan and amount applied for in accordance with its normal and customary undern standards and practices. The payment for which this receipt is issued must be one complete payment, according to the Insurer's underwriting rules, for the payment meth selected in the application. THE EVENT THE APPLICATION IS REJECTED, THE ABOVE AMOUNT WILL BE REFUNDED IN FULL BY THE INSURER.	er as ions, vriting
OTAL ANNUAL PAYMENT \$ Licensed Advisor	
heque or money order payable to La Capitale Financial Security Insurance Company must accompany the application or Authorization for the Initial Payme redit Card must be duly completed and signed.	nt by

THIS NOTIFICATION MUST BE DETACHED AND DELIVERED TO THE POLICYHOLDER/INSURED

Financial Security

LaCapital

SECT	10N 7	- D/	ΥМ	FN
JEGI				

PAYMENT METHOD SELECTION: Preauthorized Debit (PAD) Complete Section 8. Semi-annual Annual

SELECT METHOD FOR THE INITIAL PAYMENT

igle Cheque or money order attached to this application \$ _ Credit card Complete Section 9.

— Must be made out to La Capitale Financial Security Insurance Company

SECTION 8 – PREAUTHORIZED DEBIT (PAD) AGREEMENT

PREMIUM PAYOR'S INFORMATION

Policyholde	er or insured 🗌 Other: 🗆 Mr. 🗆 M	c					
		First name			Last name		
		Address (No., street, a	apt., city, province)				Postal code
		Area code	Tel.	ate of birth:	Year Month	Day	
Business:							
	Company name					Area code	Tel.
	Address (No., street, city, province)						Postal code
BANK ACCOL	JNT INFORMATION: Cheque	specimen attached to t	he application Ba	ank account info	ormation provided bel	ow.	
					,		
" 243 "	Branch number Financial A institution number A	ccount	Branch number	Financial institution number	Account number		
PAD TYPE:	Personal 🗌 Business						
this agreement have the right t contact your fin	nsurer of 10 days' written notice prior c, contact your financial institution or co receive reimbursement for any debi nancial institution or visit www.cdnpay.c ted on the enclosed cheque speciment	visit www.cdnpay.ca. Yo it that is not authorized :a. I authorize the Insure	ou have certain recour or is not consistent wi er or its agent to debit	se rights if any th this PAD agre	debit does not compl eement. To obtain more aly amounts required f La Capi	y with this agree e information abc or payments due tale Insurance a	ment. For example, you out your recourse rights
	nature of premium payor or authorize	d signatory	Date		Tel.	: 418 528-2211 o Email: fim@lac	r 1800 463-4433
SECTIO	ON 9 – INITIAL PAYM	ENT BY CRE	DIT CARD				
the Insurer's rec document of an	OTICE nich only contains information regardi cords. This is done for purposes of cor y kind whatsoever. The parties theref pect to its subject matter.	nfidentiality and compli	ance with applicable I	aws and rules. ⁻	The deletion of Part B	does not constit	ute an alteration of this
AH-261 07-201	9		4		La Capitale Financial	Security Insurar	nce Company (the Insi
	UTHORIZATION FOR THE II			2D	Authorization	lo.	
	MasterCard American		DI OREDIT OA				dministration
Credit card r					Ex	piry date:	YMN
l authorize the Insurer will rec be charged. In In the event th	e Insurer to charge the initial pay quest the necessary authorization the event the premium is increas- ne initial premium is decreased, th	from the credit card ed after my application	l issuer. If such aut on is reviewed, I aut	norization is c horize the Ins	ed credit card. Upc obtained from the cl	n receipt of th redit card issue	
SIGN HERE							
	Credit cardholder's sign	ature	Credit of	ardholder's	name		Date

ZAH-261 07-2019

REVIEW YOUR APPLICATION

time to clear up any questions is now,

before a claim arises

La Capitale Financial Security Insurance Company (the Insurer)

CLIENT INFORMATION NOTICE MIB. INC. NOTICE DATE YOUR TEN-DAY (10) RIGHT TO EXAMINE YOUR POLICY/RIDER (a) It is our wish that you fully understand and be satisfied with

NAME OF POLICYHOLDER/INSURED

Information regarding your insurability will be treated as confidential. The Insurer or its reinsurers, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 416 597-0590. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction. The address of MIB, Inc.'s information office is 330 University Avenue, Suite 501, Toronto, Ontario, Canada, MSG IR7. The Insurer, or its reinsurers, may also release information from 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, Inc. may be obtained on its website at www.mib.com. MIB, Inc. receives personal information and the collection, use and disclosure of such information is governed by the Personal Information Protection and Electronic Documents Act ("PIPEDA") and provincial laws. Therefore, MIB, Inc. has agreed to protect such information in a manner that is substantially similar to the Company's privacy and security practices, and in accordance with applicable laws. As a U.S. based company, MIB, Inc. is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. If you have any questions about MIB, Inc.'s commitment to protect the confidentiality and security of your personal information, you may contact the MIB, Inc. Privacy Department at privacy Menzeu Pri this policy/rider. If you are not satisfied with this coverage, return it to us or our agent within ten (10) days after you receive it. If you do so, this policy/rider will be deemed void from the start. Any premium paid for it will then be fully refunded.

confidentiality and security of your personal information, you may contact the MIB, Inc. Privacy Department at privacy@mib.com. **NOTICE CONCERNING THE PROTECTION OF PERSONAL INFORMATION** At La Capitale, we respect your privacy, because we know how important it is to keep your personal information confidential and secure. That is why we have adopted a Personal Information Protection Policy and implemented safeguards to protect your personal information. We collect and use your personal information to manage your Insurance, Annuity, and Credit Financial Services or Related Services insurance file. Your personal information is stored at our offices and protected by high security measures in accordance with the laws and regulations applicable to the protection of personal information. Only our employees, mandataries, distribution partners (such as agents and their firms) and service providers may access your personal information, and solely when such access is required to perform their duties, carry out their mandate or fulfil their service contract. La Capitale may do business with one or more service providers based outside of Canada. It is therefore possible that some of your personal information held by La Capitale may be stored outside of Canada and governed by the laws of foreign countries or states. If you would like to access your Service in their duties, active to use in writing to the following address: La Capitale Financial Security Insurance Company, 7150 Derrycrest Drive, Mississauga ON L5W OE5. La Capitale Financial Group Inc., its subsidiaries and their authorized representatives may use your personal information to inform you of products and services that may be of interest to you, as part of their customer service initiatives. If, however, you do not wish to receive this type of information, please write to us at the address above. For more information about our personal information protection practices, refer to our personal information protection statement at www.lacapitalefs.com/en/per HE VILW YOUR APPLICATION (b) You have signed a declaration on the application that the answers recorded on this application are your own and are true and complete. A copy of your application is enclosed in your policy. If your answers are incorrect or untrue, the Insurer may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now

ZAH-261 07-2019 THIS NOTIFICATION MUST BE DETACHED AND DELIVERED TO THE POLICYHOLDER/INSURED La Capitale Financial Security Insurance Company (the Insurer)