

APPLICATION FOR ACCIDENT ONLY INSURANCE

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

GENERAL INFORMATION

Language of correspondance: <input type="checkbox"/> English <input type="checkbox"/> French											
Last name (Policyholder/insured)					First name						
Middle name			Last name at birth (if different)				S.I.N.				
Address (No., street)							Apt.		Postal code		
City				Province	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Country of birth			
Date of birth			Home tel.			Business tel.			Extension		
Cell tel.			Best time to call <input type="checkbox"/> AM <input type="checkbox"/> PM		Best tel. number to call <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Cell			Email address			
Emergency contact name			Emergency contact tel.			Association: <input type="checkbox"/> No <input type="checkbox"/> Yes – If so, name of the association:					
Identification type (photo ID issued by a federal or provincial government):										Province or country of issue:	
Document No.:					Jurisdiction of issue:			Expiry date (if available):			
Status: <input type="checkbox"/> Canadian citizen <input type="checkbox"/> Permanent resident <input type="checkbox"/> Temporary resident <input type="checkbox"/> Other:											

SECTION 1 – PRODUCT SELECTION I hereby apply for the Accident Only coverages I have selected below:

Policy/Rider Applied For:	Policy or Rider	Elim. Period	Benefit Amount	Policy or Rider Service Premiums ¹	Annual Premium Including Service Premiums
	<input type="checkbox"/> Policy <input type="checkbox"/> Rider		\$	\$	\$
	<input type="checkbox"/> Policy <input type="checkbox"/> Rider		\$	\$	\$
	<input type="checkbox"/> Policy <input type="checkbox"/> Rider		\$	\$	\$
<input type="checkbox"/> ROP-PVR (Return of Premium Rider ²)				\$	\$
<div><div>Note 1: Policy and Rider Service Premiums are charged on an annual basis. Note 2: Policy Service Premiums, Rider Service Premiums and any fees charged with regard to a method of payment option will not be reimbursed. Note 3: This amount includes the Policy and Rider Service Premiums and any applicable taxes (e.g., PST) and fees.</div><div>Provincial Sales Tax (PST) if applicable TOTAL ANNUAL PAYMENT³</div></div>				\$	\$

SECTION 2 – INCOME AND OCCUPATION

Part A (Self-Employed) Occupation and exact duties:									
Type of business: <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation				If owner, percentage of ownership: _____		Home based business? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Company name: _____						Date business started: _____			
Hours per week worked: _____			Years in industry: _____			Number of employees: _____			
Have you filed for bankruptcy in the last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No				If Yes, when was your bankruptcy discharged? Date: _____					
What estimated percentage of work is: Labour ____ % Administrative ____ % Supervisory ____ % Client Relation/Marketing ____ % Actual Driving ____ %									
If less than 12 months earned, indicate number of months earned – do not project earnings (last 2 years)									
						20		20	
						Gross annual Business income			
						Less all operating Expenses		-	
						Net earned annual income ⁴		=	
Part B (Employee) Occupation and exact duties:									
Employer's name, address & phone number: _____									
Hours per week worked: _____				Years employed: _____		Gross earned annual income ⁴ : \$ _____			
COMPLETED BY: <input type="checkbox"/> SALES OFFICE <input type="checkbox"/> AGENT/ADVISOR									
The individual who wrote this application must be listed below as either Agent/Advisor 1, 2, 3 or 4 and provide his/her own agent code.									
Sales/Regional Office/Mail Code: _____									
Agent/advisor 1 name: _____				Agent/advisor code: _____			Share %: _____		
Agent/advisor 2 name: _____				Agent/advisor code: _____			Share %: _____		
Agent/advisor 3 name: _____				Agent/advisor code: _____			Share %: _____		
Agent/advisor 4 name: _____				Agent/advisor code: _____			Share %: _____		
Complete when partnership, business or family applications are being submitted together:									
<input type="checkbox"/> Group with Last name First name									

SECTION 3 – COMPLETE IN ALL CASES

Present Height: _____ ft. _____ in. or _____ cm										Present Weight: _____ lbs. 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		3. In the last 3 years, have you had any indication or medical treatment or consulted a physician for alcohol/drug usage? (If Yes, complete Alcohol/Drug, ZL-436 Usage Questionnaire.)				Yes No									
2. Within the last 3 years:						4. Do you engage in competitive racing or speed contests (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?						b) Are you applying for any other coverage with La Capitale?..... (If Yes, please provide details in chart provided below.)													
c) have you been charged with impaired driving under the Criminal Code, been charged with careless or dangerous driving, or had your driver's licence suspended?						6. Do you have a valid driver's licence?													
d) have you been incarcerated?																			
e) have you had 3 or more moving violations?																			
Provide details for Question #5 in this chart.	Name of company		Year of Issue	Life Insurance		Monthly Benefit	Accidental Death	Benefit Period		Elimination		Pending, Retaining or Replacing							
				Plan	Amt			Acc.	Sick.	Acc.	Sick.	<input type="checkbox"/> PENDING <input type="checkbox"/> RETAINING <input type="checkbox"/> WILL IMMEDIATELY REPLACE UPON ACCEPTANCE OF THE INSURER							

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 BENEFIT SECTION

Have you lost more than 4.5 kgs (10 lbs.) in the last year? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, number of kgs (lbs.) lost and reason: _____													
Name of physician: _____ Phone number: _____													
Address: _____													
Date of last consultation: _____ Reason: _____ Result: _____													
1. Within the last 10 years:				Yes No		v. chronic pain or fatigue, fibromyalgia, Epstein-Barr syndrome or sleep apnea?				Yes No			
a) have you received benefits from any source?						vi. diabetes, elevated sugar in blood or urine?							
b) have you used or do you currently use narcotics, hallucinogens, barbiturates, amphetamines, marijuana, cocaine, heroin or other drugs except as prescribed by a physician?						2. Within the last 3 years:							
c) have you had any indication or medical treatment or consulted a physician for alcohol/drug usage?						a) have you engaged or intended to engage in any hazardous activities such as, but not limited to (a) rodeo, (b) mountain or rock climbing, (c) hang gliding, (d) parachuting, (e) competitive racing or speed contests (not limited to vehicles)?							
d) have you ever been treated for or advised for, or had any indication of:						b) have you been advised to have any diagnostic test (other than any related to genetic testing) or surgery which has not been done yet, or has been completed but the results not received?							
i. 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.)						c) have you ever had a life, critical illness, long-term care or disability insurance application declined, deferred, modified or rated with a higher premium?							
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?						3. Have you ever been treated for, tested positive or been diagnosed as having an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or Aids-Related Complex (ARC) or tested positive for HIV?							
iii. dizziness/fainting, epilepsy, paralysis, dementia, Alzheimer's, Parkinson's or organic brain disease?						4. Are you currently taking any prescribed medications?							
iv. depression, schizophrenia, other mental or nervous disorder?						(If Yes, provide details in the chart provided below, including list of medications and dosages.)							
If any questions in SECTION 3 or 4 have been answered "Yes", please provide details 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						

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.

Date: _____ Signature of policyholder/insured: **X**_____

DO NOT DETACH THIS AUTHORIZATION – RETURN TO HEAD OFFICE

SECTION 5 – BENEFICIARY DESIGNATION

The terms “estate”, “successors” or “legal heirs” refer to the policyholder/insured’s estate, successors or legal heirs. 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**.

	Last name	First name	Date of birth (MM/DD/YYYY)	Relation to policyholder/insured	Select designation	
					Revocable	Irrevocable
Primary					<input type="checkbox"/>	<input type="checkbox"/>
Contingent					<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6 – DECLARATION & AGENT/ADVISOR STATEMENT

DECLARATION – I hereby apply to La Capitale Financial Security Insurance Company (the Insurer) for an insurance policy to be issued in reliance upon the written answers to the questions in this application. I agree that the answers recorded on this application are my own and are true and complete. I agree and understand that the application is not be binding upon the Insurer until approved by the Insurer.

Dated at: City _____ Province _____ on _____
Month Day Year

Signature of policyholder/insured: **X** _____

AGENT/ADVISOR STATEMENT

If Delivery Has No Requirements: ☐ MAIL POLICY TO POLICYHOLDER/INSURED ☐ MAIL POLICY TO OFFICE

I hereby certify that I have truly and accurately recorded on this application the information supplied by the policyholder/insured. 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.

	Yes	No
Can the policyholder/insured read, speak and understand <input type="checkbox"/> English or <input type="checkbox"/> French?	<input type="checkbox"/>	<input type="checkbox"/>
If “NO” have you fully explained the details of the application to the policyholder/insured and are you satisfied that the application is fully understood?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any knowledge of the policyholder/insured personal habits, health, avocations, finances or reputation that might affect the underwriting risk?	<input type="checkbox"/>	<input type="checkbox"/>
I have given the policyholder/insured the MIB, Inc. Notice and Client Information Notice	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Licensed Agent/Advisor

Signature of Training Supervisor (If required under provincial legislation)

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 #):
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 as applicable 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:

- 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 underwriting 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 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 \$ _____ Licensed Advisor _____

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.

