La Capitale
Insurance and
Financial Services

Application Form
Deferred Life Annuity (RSP)

1. CONTRACTHOLDER'S PERSONAL INFORMATION

Last name _____ First name _____ Gender: ☐ M ☐ F

Address (No., Street, Apartment) _____ Town/City _____ Province _____ Country _____ Postal code _____

Telephone (home) _____ Telephone (work) _____ Ext. _____ Social Insurance No. _____

Date of birth (YYYY/MM/DD) _____ E-mail address _____ Language preference: ☐ French ☐ English

2. BENEFICIARY DESIGNATION

☐ **ESTATE**
OR
☐ **DESIGNATION**

Beneficiary's name	Relationship to contractholder	Date of birth (YYYY/MM/DD)	Revocable	Irrevocable
			☐	☐
			☐	☐
			☐	☐

CAUTION: If you live in Quebec and the beneficiary you have named is the person to whom you are married or civilly united, this designation is considered irrevocable unless you indicate that you wish 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, you must obtain the beneficiary's consent. If the irrevocable beneficiary is a minor, the consent of the beneficiary's legal guardian is required in addition to any other legal formalities.

3. CHOICE OF PLAN AND PAYMENT METHOD

☐ INSTALMENT PREMIUM DEFERRED LIFE ANNUITY

Annual premium: $ _____ /year

☐ **Preauthorized payment** $ _____
Please complete Section 5

☐ **Cash deposit by cheque** $ _____

Date of cheque (YYYY/MM/DD) _____

☐ **Amount already held with insurer** $ _____

Account No. _____

☐ **Transfer from another institution** $ _____

Please enclose the transfer request and a copy of a statement if possible.
Subsequent years will be billed to you annually.

Maturity date of investment (YYYY/MM/DD) _____

Name of financial institution or employer _____

Address of institution:

No., Street _____ Town/City _____

Province _____ Country _____ Postal code _____

☐ SINGLE PREMIUM DEFERRED LIFE ANNUITY

Single premium: $ _____

☐ **Cash deposit by cheque** $ _____

Date of cheque (YYYY/MM/DD) _____

☐ **Amount already held with insurer** $ _____

Account No. _____

☐ **Transfer from another institution** $ _____

Please enclose the transfer request and a copy of a statement if possible.

Maturity date of investment (YYYY/MM/DD) _____

Name of financial institution or employer _____

Address of institution:

No., Street _____ Town/City _____

Province _____ Country _____ Postal code _____

DISBURSEMENT DATE OF DEFERRED LIFE ANNUITY: _____ (YYYY/MM)

4. ADDITIONAL BENEFIT

☐ Waiver of premiums in the event of the contractholder's disability (WPDI) – applies only to Instalment Premium Deferred Life Annuity

Please complete and sign the declarations of insurability and sign the medical authorization.

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5. PREAUTHORIZED DEBIT (PAD) AGREEMENT

I, the undersigned, authorize La Capitale Insurance and Financial Services Inc. or its agent to debit the fixed monthly amounts required for payment of the sums due to La Capitale Insurance and Financial Services Inc. from the account indicated on the enclosed cheque specimen or from the account identified hereafter.

Bank account information

Please enclose a cheque specimen **or** complete

TRANSIT	BANK	ACCOUNT NO.

Type of PAD: Personal

☐ Date of withdrawal determined by insurer at time of issue or specify the _____ of each month.

You will receive notice at least ten (10) days prior to the scheduled date of the first PAD confirming the amount and date of the PADs. This agreement may be cancelled upon receipt by La Capitale Insurance and Financial Services Inc. of at least thirty (30) days' written notice prior to the scheduled date of the next PAD. Furthermore, 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 PAD that is not authorized or is not consistent with this agreement.

To obtain a sample PAD cancellation form, or for more information about your right to cancel this agreement or your other rights to recourse, contact La Capitale Insurance and Financial Services Inc. or visit www.cdnpay.ca.

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

PAYER'S SIGNATURE (the payer must be the contractholder)

X _____

La Capitale Insurance and Financial Services Inc.
625 Saint-Amable St., Quebec QC G1R 2G5
Tel.: 418 528-2211/1 800 463-4433 • E-mail: fim@lacapitale.com

6. RATE GUARANTEE

In the event that the rate used for the quotation does not match that specified by the Insurer or any information used to determine the annuity is revealed to be false, the Insurer reserves the right to adjust the annuity to the rate specified or in accordance with the true information.

In the case of a transfer from another financial institution, the annuity rate is guaranteed for a period of 60 days from the date this application is signed, provided the cheque is received and cashable before the end of this period.

7. DOCUMENTS TO ENCLOSE WITH APPLICATION

> Duly signed product illustration
> Cheque specimen or cheque, as applicable
> Declarations of insurability and medical authorization, if WPDI applied for
> Transfer form, if applicable (to be used for transfers from other financial institutions):

- **T2033:** From an RRSP or RRIF to another RRSP or RRIF
- **T2151:** Transfer of a pension fund
- **T2220:** From an RRSP or RRIF to another RRSP or RRIF on Marriage Breakdown
- **TD2:** Retirement or illness benefit
- Non-registered external transfer
- **Death:** Death
- **Vacations:** Vacation pay, bonuses, retroactive payments

8. CONTRACTHOLDER'S DECLARATION

I have verified the information contained in this application and certify it to be true and complete. I have read the enclosed illustration and I acknowledge that my advisor has provided all necessary information for my comprehension of the Deferred Life Annuity, notably regarding the percentage of premiums that will be reimbursed to me and regarding the fees and penalties that may apply in the event of surrender prior to the disbursement date.

I hereby request that this Deferred Life Annuity contract be issued on the basis of this information and I authorize the Insurer to proceed with registration of this plan as a registered retirement savings plan in accordance with income tax legislation.

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

SIGNATURE

X _____
Contractholder's Signature

X _____
Signature of Financial Security Advisor

SECTION FOR ADVISOR USE ONLY

Servicing advisor

Advisor name	Advisor code	General Agent	General agent code

Commissions

Advisor name	Advisor code	Split %	General Agent	General agent code

☐ I don't have an advisor code. This is my first application.

☐ I don't have an advisor code. This is my first application.

Commission type: ☐ Regular ☐ Level

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Declarations of Insurability

Complete only if you wish to apply for the Waiver of premiums in the event of the contractholder's disability benefit

A1. INSURANCE IN FORCE OR PENDING

☐ **NONE**
OR

Type of insurance	Insured amount	Accidental Death	Company name	Year of issue (check if pending) P	Personal/ Commercial P	C
	$	$		☐	☐	☐
	$	$		☐	☐	☐

Have you ever had a life, critical illness or disability insurance application declined, deferred, modified or rated with a higher premium? ☐ Yes ☐ No

If yes,

Month	Year	Company name	Decision	Reason

A2. TOBACCO USAGE

During the last 12 months, have you smoked cigarettes, cigarillos, cigars or a pipe, or have you used any form of tobacco or marijuana, or used a substitute such as a nicotine patch or gum? ☐ Yes ☐ No

If yes,

Type _____ Quantity _____ Frequency _____

If not, have you ever used tobacco in the past? ☐ Yes ☐ No **If yes, when did you quit?** (YYYY/MM) _____

A3. PERSONAL INFORMATION

If you answer YES to any of the questions (except questions 1 and 7), please complete the "Explanations" part of the Medical Information section.

Information

Name at birth _____ Place of birth: (Province/Country) _____ In Canada since (YYYY/MM) _____

Name of current employer _____ Occupation _____

			Yes	No
Alcohol	1.	Do you drink alcohol?	☐	☐
		If yes, current weekly consumption (number of glasses of beer, wine and/or spirits). _____		
	2.	Has your consumption of alcohol changed in the last 5 years?	☐	☐
		If yes, previous weekly consumption (number of glasses of beer, wine and/or spirits). _____		
	3.	When did you reduce your consumption? (YYYY/MM)		
Drug use	4.	Do you take, or have you ever taken drugs?	☐	☐
Driving record		Within the last 5 years:		
	5.	Has your driver's licence been suspended or revoked?	☐	☐
	6.	Have you been found guilty of 3 or more traffic violations?	☐	☐
Criminal record	7.	Have you ever been charged with or found guilty of any criminal offence?	☐	☐
		If yes, please specify the type, date, sentence and probation for each offence.		
Travel	8.	Do you plan to travel or reside outside of Canada and the United States?	☐	☐
Hazardous sports	9.	In the last two years, have you taken part in, or do you plan to take part in:		
		a) scuba diving, skydiving, hang gliding, mountain climbing, motor vehicle racing or any other hazardous sport or activity?	☐	☐
		b) any flights other than as a passenger?	☐	☐

A4. MEDICAL INFORMATION

Personal physician

Name of physician _____ Telephone _____

Address _____

Last physician consulted, if different _____ Date of last consultation (YYYY/MM/DD) _____ Reason _____

Results (consultations or treatments recommended) _____

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A4. MEDICAL INFORMATION (cont.)

Height and weight

Height: ☐ cm ☐ ft/in	Weight: ☐ kg ☐ lb	Have you lost more than 4.5 kg (10 lb) in the last year? ☐ Yes ☐ No	If yes, no. of kg (lbs) lost: ☐ kg ☐ lb	Reason for weight loss

Family history

Have any of your immediate family members (father, mother, brothers, sisters) ever suffered from heart or vascular disease, high blood pressure, cerebrovascular trauma, cancer, diabetes, polycystic kidney disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's Chorea, amyotrophic lateral sclerosis or any other hereditary disease? ☐ Yes ☐ No

If yes,

	Name of disease (if cancer, specify type)	Age at diagnosis	Age if alive	Age at death	Cause of death
Father					
Mother					
Brother(s)					
Sister(s)					

Medical history

Check YES or NO and circle all situations/conditions/(YES) answers that apply. Provide details for every YES answer in the "Explanations" section

		Yes	No
1.	Have you ever consulted for, been treated for or showed signs or symptoms of the following conditions:		
	a) Heart attack, high blood pressure, chest pain, high level of cholesterol, cerebrovascular accident (stroke), aneurism or any other heart or blood vessel disorder?	☐	☐
	b) Cancer, tumor, leukemia, lymph node disorder, cyst, polyp, skin disorder, breast disorder, including lumps, unusual discharge or other physical changes?	☐	☐
	c) Diabetes, disorder of the thyroid gland or other endocrine disorder?	☐	☐
	d) Epilepsy, paralysis, multiple sclerosis, coma, Alzheimer's disease, Parkinson's disease, dizziness, loss of balance, optic neurosis, blurred vision, numbness or any other neurological disorder, depression, burn-out or any other psychological, psychiatric or mental disorder?	☐	☐
	e) Hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or other disorder of the liver, stomach or intestines?	☐	☐
	f) Asthma, emphysema, chronic bronchitis or any other pulmonary or respiratory disorder?	☐	☐
	g) Disorder of the bladder, prostate, genitals or reproductive system, kidneys or urine abnormalities?	☐	☐
	h) Immune system disorder, AIDS or positive test results for HIV (human immunodeficiency virus)?	☐	☐
	i) Arthritis, pain in the vertebral column or other bone or joint disorder?	☐	☐
	j) Anemia or other blood disorder, eye or ear disorder or any other disorder not mentioned above?	☐	☐
	k) Do you have any symptoms or signs for which you have not yet consulted?	☐	☐
2.	Have you ever received treatment or have you been advised to undergo treatment or to consult a physician regarding your consumption of drugs or alcohol?	☐	☐
3.	Within the last 5 years, have you undergone medical tests, X-rays, blood tests, follow-up, screening or other diagnostic tests?	☐	☐
4.	Do you have to consult a physician, undergo a treatment, surgery or tests which have not yet been performed?	☐	☐
5.	Within the last 5 years, have you been disabled or absent from work for a consecutive period of 4 weeks or more due to illness or injury?	☐	☐
6.	Are you taking any medication? (If yes, specify)	☐	☐
7.	Have you ever consulted a physician for, received a diagnosis or showed symptoms of abnormal findings after a mammography or biopsy?	☐	☐
8.	Within the last 2 years, have you undergone a mammography or breast ultrasound?	☐	☐

Leave this blank

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A4. MEDICAL INFORMATION (cont.)

Explanations

For each "Yes" answer in the Personal Information and Medical History sections, explain opposite.

If you need extra space, attach an extra sheet to this form and ensure it is signed and dated.

Question No.	Dates of consultations, reasons, results, hospitalization, surgery, names and addresses of physicians consulted and/or hospitals visited

Signature I confirm that the answers given in this questionnaire are true and complete.

Date (YYYY/MM/DD)	X Signature of Proposed Insured	Signature of Financial Security Advisor

Complete only if you wish to apply for the Waiver of premiums in the event of the contractholder's disability benefit

Medical Authorization

I authorize the Insurer and its reinsurers, for the strict purposes of determining insurability, file management and claims settlement:

a) to gather only that information necessary regarding my file from any individual or organization or public or parapublic institution holding personal information about us, notably from health professionals and medical establishments, the Medical Information Bureau, financial institutions, insurance and reinsurance companies, personal information agents, investigation agencies, employers or previous employers;
b) to disclose to such individuals and organizations only that personal information it has about me that is relevant to my file;
c) to request an investigation report about me;
d) to provide a report about me to the Medical Information Bureau.

In the event of death, I specifically authorize the contractholder, the beneficiary, the heir or the liquidator of my estate to provide the Insurer or its agents when necessary with all information or authorizations required in the processing of my file.

A photocopy of this authorization shall be considered as valid as the original.

SIGNATURE OF PROPOSED INSURED

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

La Capitale
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gestion du patrimoine

100 %