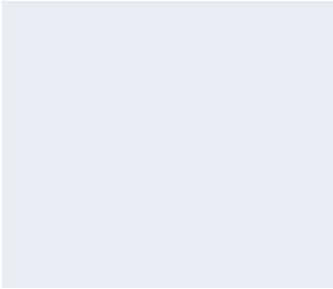


# APPLICATION - ACCI-JET PROGRAM

New sale	<input type="checkbox"/>	
Change in coverage	<input type="checkbox"/>	Contract # <input type="text"/>



Name of representative <input type="text"/>	Email address of representative* <input type="text"/>	Code <input type="text"/>	<input type="text"/>	%
Name of representative <input type="text"/>	Email address of representative* <input type="text"/>	Code <input type="text"/>	<input type="text"/>	%
Firm <input type="text"/>	Email address of firm* <input type="text"/>	Code <input type="text"/>		

\*If your current email on file has not changed, please leave this field blank.



INVESTED IN YOU.



## 1 GENERAL INFORMATION (Policyholder / Primary Insured)

Last name		Home address	
<input type="text"/>		no.   street   apt./condo	
First name		City	
<input type="text"/>		<input type="text"/>	
Email address		Province	Postal code
<input type="text"/>		<input type="text"/>	<input type="text"/>
Date of birth	Gender	Home/Cell telephone number	Office telephone number Ext.
Y   M   D <input type="checkbox"/> Save age	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="text"/>	<input type="text"/>
If Canada, specify the Province: <input type="text"/>   If USA, specify the State: <input type="text"/> If other than Canada, Y   M   D <input type="text"/>		Name of company (Policyholder <input type="checkbox"/> Yes <input type="checkbox"/> No)	Date of employment
Current legal status <input type="checkbox"/> Canadian citizen <input type="checkbox"/> Permanent citizen <input type="checkbox"/> Other*, specify: <input type="text"/>		Business address <input type="checkbox"/> Same as home address	Y   M   D <input type="text"/>
* Please attach a copy of your work permit and proof of your permanent residence application if any.		no.   street   suite	City   Province   Postal code
		Language of correspondence	Mailing address
		<input type="checkbox"/> English <input type="checkbox"/> French	<input type="checkbox"/> Home <input type="checkbox"/> Office

## 2 OCCUPATION

Occupation*	Brief description of tasks	Manual tasks <input type="text"/> %	Annual Income (see section 3)
<input type="text"/>	<input type="text"/>	Administrative tasks or Supervision <input type="text"/> %	\$ <input type="text"/>

\*Please use the exact occupation wording as stated in the Rate Guide

Do you pay contributions to Employment Insurance (EI)? Yes  No  Do you work from home more than 50% of the time? Yes  No

Are you a truck driver? Yes  No  If yes, percentage of manual labour and/or requiring physical work  %

## 3 EVALUATE YOUR ANNUAL INCOME

NET ANNUAL INCOME (after expenses but before income tax): \$

### TO BE FILLED OUT ONLY IF YOU ARE A BUSINESS OWNER

<b>GROSS INCOME</b>	Gross business revenue	\$ <input type="text"/>	<b>NET INCOME</b>	Net business revenue	\$ <input type="text"/>
	Cost of goods	\$ <input type="text"/>		Insured's salary	\$ <input type="text"/>
	Salaries and employee benefits (Except those of the Insured)	\$ <input type="text"/>		Total	\$ <input type="text"/>
	Total	(1) \$ <input type="text"/>			

The **ANNUAL INCOME** is the greater of 50% of (1) or 100% of (2) \$

## 4 POLICYHOLDER (To be completed if other than Insured)

Last name		Home address <input type="checkbox"/> Same as the Insured	
<input type="text"/>		no.   street   apt./condo	
First name		City	Province   Postal code
<input type="text"/>		<input type="text"/>	<input type="text"/>
Date of birth	Gender	Relationship to Insured	Home/Cell telephone number   Office telephone number   Ext.
Y   M   D	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="text"/>	<input type="text"/>

## 5 BENEFICIARY (for AD&D and Overhead Expense Insurance)

Last Name	First Name	Gender	Distribution	Status*	Relationship to Primary Insured
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="text"/> %	Revocable <input type="checkbox"/> Irrevocable <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="text"/> %	Revocable <input type="checkbox"/> Irrevocable <input type="checkbox"/>	<input type="text"/>

\*A beneficiary is always revocable unless designated specifically as irrevocable, with one exception: where Quebec's Civil Code applies, a beneficiary who is married to or in a civil union with the Primary Insured is always irrevocable unless designated specifically as revocable.

## 6 FAMILY COVERAGE

If you selected coverage for your spouse and/or children, please fill out this section for every dependent.

Last Name	First Name	Gender	Relationship	Date of birth		
		<input type="checkbox"/> F <input type="checkbox"/> M		Y	M	D
		<input type="checkbox"/> F <input type="checkbox"/> M		Y	M	D

## 7 OTHER INSURANCE CONTRACT(S)

Do you currently hold any other insurance contract(s), excluding creditor group insurance?  Yes  No

Type	Company	Year Issued	Amount	Under Review	In Effect	To Replace*
<input type="checkbox"/> Life <input type="checkbox"/> Disability			\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Life <input type="checkbox"/> Disability			\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Life <input type="checkbox"/> Disability			\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*If the insurance applied for replaces any other insurance currently in force, you are required to attach the comparative statement (Quebec: disability and life / Outside Quebec: life only).

## 8 ELIGIBILITY – DISABILITY INSURANCE IN THE EVENT OF AN ACCIDENT OR SOFT TISSUE INJURY

- 1- Do you currently hold remunerative work for at least eight months per year and 21 hours per week? Yes  No
- 2- Are you currently limited in terms of your movements or your daily activities due to an injury or illness? Yes  No
- 3- Do you have a chronic neurodegenerative disease or a permanent physical or intellectual impairment? Yes  No

If the answer to question 1 is "NO" or if the answer to questions 2 or 3 is "YES", YOU ARE NOT ELIGIBLE for this product.

## 9 ELIGIBILITY FOR DISABILITY INSURANCE IN THE EVENT OF AN ILLNESS

If you answer "YES" to any of the following medical and non-medical questions, YOU ARE NOT ELIGIBLE for disability insurance in the event of an ILLNESS.

### A MEDICAL QUESTIONS

1- Is your weight greater than the weight corresponding to your height in the following table? Yes  No

Height/feet	Weight/pounds	Height/metres	Weight/Kilograms
4'10" to 5'2"	210 lb.	1.47 m to 1.58 m	95 kg
5'3" to 5'6"	234 lb.	1.59 m to 1.68 m	106 kg
5'7" to 5'10"	264 lb.	1.69 m to 1.78 m	119 kg
5'11" to 6'2"	294 lb.	1.79 m to 1.88 m	133 kg
6'3" to 6'7"	324 lb.	1.89 m to 2.01 m	146 kg

2- In your lifetime, have you suffered from or been treated for any of the following conditions:

- a) Acquired immunodeficiency syndrome (AIDS) or tested positive for the human immunodeficiency virus (HIV)? Yes  No
- b) Heart attack (myocardial infarct), angina, heart valve disease, cerebrovascular disease (stroke), transient ischemic attack (TIA), aneurysm, or any other heart or blood vessel disorders? Yes  No
- c) Leukemia, lymphoma, malignant tumour or any other form of cancer (other than basal cell carcinoma)? Yes  No
- d) Crohn's disease, ulcerative colitis, chronic liver disease (including cirrhosis, fibrosis, hepatitis C or any other type of chronic hepatitis), or pancreatitis? Yes  No
- e) Polycystic kidney disease or kidney failure? Yes  No
- f) Type 1 diabetes or any of the following complications as a result of type 2 diabetes: eye disorders, peripheral nerve damage or kidney disorders? Yes  No

3- Within the last five (5) years, have you suffered from or been treated for any of the following conditions:

- a) Asthma which requires daily treatment, chronic bronchitis, emphysema, cystic fibrosis, sarcoidosis or sleep apnea? Yes  No
- b) Any kidney or genitourinary system disease requiring regular supervision (i.e. more than one visit per year) by your physician or a specialist? Yes  No
- c) Any type of arthritis (excluding osteoarthritis), any type of lupus, muscular dystrophy or degenerative disc disease, including herniated disc? Yes  No

4- Within the last twelve (12) months:

- a) If you have type 2 diabetes, has your medication changed as advised by a physician (addition or replacement of a medication, increase or decrease of dosage)? Yes  No
- b) Has an illness or injury resulted in absence from work for more than two consecutive weeks? Yes  No

**A** MEDICAL QUESTIONS (cont'd)

- 5- Presently, do you require regular supervision (i.e. more than one visit per year) by your physician or a specialist for all diseases or disorders of the eyes, ears, nose, throat, skin or blood? Yes  No
- 6- Have you been advised to have any tests, consult with a physician (other than as part of a routine examination or government prevention program) or undergo surgery, that is still pending? Yes  No
- 7- Has a member of your immediate family (father, mother, brother or sister) been diagnosed before the age of 60 with:
- a) Breast or ovarian cancer, colon cancer or familial adenomatous polyposis? Yes  No
- b) Huntington's disease or polycystic kidney disease? Yes  No

**B** NON-MEDICAL QUESTIONS

- 1- Within the last five (5) years:
- a) Have you used hard drugs or narcotics without a medical prescription? Yes  No
- b) Have you been treated for drug or alcohol use, joined a support group or been advised to reduce your consumption or to receive treatment for it? Yes  No
- 2- Within the last twelve (12) months, have you been convicted of an offence or criminal act, or are you currently under indictment for an offence or criminal act, or your license has been suspended, withdrawn or restricted (for any reason other than unpaid tickets)? Yes  No

**10** SUMMARY OF REQUESTED COVERAGES

Occupational class  C /  B /  1A /  2A /  3A /  4A |  LEVEL COMMISSION (default)  UP-FRONT COMMISSION (not available for truck drivers)

DISABILITY INSURANCE IN THE EVENT OF AN ACCIDENT OR SOFT TISSUE INJURY										
WAITING PERIOD Number of days	COVERAGE		BENEFIT PERIOD			ADDITIONAL OPTIONS			SUM INSURED	MONTHLY PREMIUM
	24-hour	Non-work related	2 years	5 years	Up to age 70	Partial Disability	Return of Premiums	Extension of regular occupation (5 years)		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	\$
<b>Overhead Expense Insurance</b>									\$	\$

DISABILITY INSURANCE IN THE EVENT OF AN ILLNESS										
WAITING PERIOD Number of days	COVERAGE		BENEFIT PERIOD			ADDITIONAL OPTIONS IDENTICAL TO THOSE SELECTED FOR DISABILITY INSURANCE IN THE EVENT OF AN ACCIDENT OR SOFT TISSUE INJURY	SUM INSURED	MONTHLY PREMIUM		
	24-hour	Non-work related	2 years	5 years	Up to age 70					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		\$	\$		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		\$	\$		
<b>Overhead Expense Insurance</b>									\$	\$

OPTIONAL COVERAGE										
<b>ACCIDENTAL DEATH, DISMEMBERMENT OR LOSS OF USE</b> (From \$25,000 to \$350,000 by increments of \$25,000)										\$
<b>ACCIDENTAL FRACTURE</b> (1 unit: \$5,000, 2 units: \$10,000)										\$
<b>EXTENDED MEDICAL CARE FURTHER TO AN ACCIDENT</b> (Monthly premium: \$2.50)									<input type="checkbox"/>	\$
<b>TRAVEL INSURANCE</b> Primary Insured: P Family: F									P <input type="checkbox"/> F <input type="checkbox"/>	\$

POLICY FEE										
A minimum annual premium of \$100 applies to each contract. For an annual payment, monthly premium X 12.									<b>TOTAL</b>	\$ 2.50
										\$

## 11 METHOD OF PAYMENT

I hereby authorize **The Excellence Life Insurance Company** to draw monthly payments from my bank account at my financial institution for the purposes of paying the insurance premium. This authorization concerns pre-authorized debits in the "personal" category. I will receive, at least ten days before the first pre-authorized debit and before any change in the date of the debit or in the amount to be debited, a notice to this effect. I will also receive a notice in the event that an **instrument is returned by the bank marked "insufficient funds" or "stop-payment order"**. Note that an administrative fee will apply to any returned instrument and will be payable at the same time as the returned amount and at the next regular payment. Please note that the first pre-authorized debit will be adjusted to reflect the actual period between the first premium paid, the effective date of the coverages and the date you chose for the debits. The debits that follow will correspond to the monthly premium. This authorization may be revoked at any time upon receipt of a written notice from me to The Excellence Life Insurance Company at least ten days before the due date of the next pre-authorized debit. Certain recourses are available to me and I can, for example, dispute a pre-authorized debit if it is not in accordance with this authorization. To obtain the reimbursement form or for any information, you may contact your financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca). For more information, you may contact our Clients and Partners Contact Center at 1-800-465-5818 or by e-mail at [intouch@iaexcellence.com](mailto:intouch@iaexcellence.com).

**Important notice: in case of any banking issues, a \$5 service fee will apply.**

**Annual premium** → Please make your cheque out to **The Excellence Life Insurance Company**.

First premium		Subsequent premiums	
<input type="checkbox"/> Cheque attached made out to <b>The Excellence Life Insurance Company</b>		<input type="checkbox"/> Pre-authorized debit on the <input type="text"/> of each month (1 <sup>st</sup> to 28 <sup>th</sup> )	
<input type="checkbox"/> Pre-authorized debit upon receipt of application		If no date is given, premium will be withdrawn on effective date of contract.	
		<input type="checkbox"/> Same account as for contract # <input type="text"/>	
Please enclose a specimen cheque marked "Void" OR please provide the name of your financial institution <input type="text"/>			
Transit number <input type="text"/>	Financial institution number <input type="text"/>	Account number <input type="text"/>	
(5 digits)	(3 digits)	(write all digits)	
<input type="text"/>	X	Y   M   D	
Name of payor	Signature (as it appears on cheques)	Date	

## 12 DECLARATION

I understand and accept that:

- the information provided in this application is true and complete and acknowledge that it constitutes the basis for insurance coverage;
- if any misrepresentation or omission is made, the Insurer shall not be held to any obligation under any insurance that may be issued to me further to acceptance of my insurance application;
- all benefits payable are subject to the conditions, definitions, limitations and exclusions set out in the contract. I have also read the explanatory product brochure, which explains the main conditions, limitations and exclusions, and I further confirm that my representative has had the opportunity to explain the details of the contract to me;
- disability insurance will take effect the same day the application is received at the iA Excellence head office. Coverage will take effect only if the first premium has been paid and payment is honoured upon initial presentation.
- I undertake to inform the Insurer of any change in my insurability, including my health, between the time of signature of this application and the date the requested contract will be in force.
- iA Financial Group, its affiliates and their agents can access information about me in order to know me better, better meet my needs and offer the best possible service and client experience. (If you do not wish to allow this access, please notify us by email at [intouch@iaexcellence.com](mailto:intouch@iaexcellence.com) or by mail to The Excellence Life Insurance Company, c/o Clients and Partners Contact Center, 1611 Crémazie Blvd. East, Suite 900, Montreal, Quebec, H2M 2P2.)

Signed at  City  This  Y | M | D

X	X	X
Signature of Primary Insured	Signature of policyholder (if other than Insured)	Signature of Representative

### 13 AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION TO THIRD PARTIES



**The Excellence Life Insurance Company**  
1611 Crémazie Blvd. East, Suite 900  
Montreal, Quebec, H2M 2P2  
Telephone : 514 327-0020 / 1 800 465-5818

I, the proposed insured and applicant, hereby authorize any person or any other public, quasi-public or private institution holding my personal information, including: any health care professional, health or social service establishment, the Régie de l'assurance maladie du Québec, any insurance or reinsurance company, MIB Inc., financial institutions, personal information agents or professional investigation agencies, financial consultants, my employer or ex-employer, the policyholder and any other body holding personal, administrative, medical or health-related information concerning myself to supply this information to The Excellence Life Insurance Company and their respective reinsurers for the risk assessment, for case management or for any investigation required for the study of any claim. I also authorize The Excellence Life Insurance Company to exchange personal information with these people and entities, as well as with their reinsurers, as required. A photocopy or electronic version of this authorization is as valid as the original.

<input type="text"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Last name and first name of Primary Insured	Signature of Primary Insured	Date

DETACH AND GIVE THIS SECTION TO THE PRIMARY INSURED

AP-AJE 04-2019

### 14 NOTE REGARDING MIB INC. (MIB)

The primary objective of the Company is to provide its clients with financial security at the lowest possible cost. In order to achieve this goal in a fair and equitable manner with respect to all policyholders, the Company must assess the risk associated with every insurance application. Your application is reviewed based on information from various sources of data that you have provided regarding your medical history, the results of any medical examination or test deemed necessary, reports received from the physicians you consulted and the hospitals where you stayed as a patient, as well as information regarding your character, your financial reputation, your personal expenses and your lifestyle.

All information concerning your insurability is considered confidential. However, the Company or its reinsurers may submit a summary of that information to MIB Inc., a non-profit organization created by life insurance companies that exchanges information on behalf of its member companies. If you purchase life or health insurance from another MIB member company, or if you claim benefits from that company, MIB Inc. will, upon request, provide that company with the information it holds regarding you.

If you send MIB Inc. a request to this effect, MIB Inc. will take steps to provide you with the information in your record. If you challenge the accuracy of the MIB's information, you may send a request to correct your record to the following address:

**MIB Inc., 330 UNIVERSITY AVENUE, TORONTO, ONTARIO, M5G 1R7 TEL. (416) 597-0590**

The Company and its reinsurers may also communicate the information in their records to other life insurance companies with which you apply for life or health insurance or with which you file a claim.

#### NOTICE REGARDING THE CREATION OF A PERSONAL FILE

The personal information that the Company holds or will hold concerning you will be treated confidentially and kept in a file, the purpose of which is to allow you to benefit from various financial insurance services and related services that the Company offers. The file will be consulted only by authorized personnel, including the Company's reinsurers, who must access the information as part of their work. You may access your file and request corrections to the information therein if you show that the information is untrue, incomplete, ambiguous, no longer valid or unnecessary. In this case, you must send a written request to the Access to Information Officer at the Montreal head office.

The Company may create a list of clients for business or philanthropic prospecting purposes. However, it is your right to have your name removed from that list by sending a written request to the Access to Information Officer at the Montreal head office (1611 Crémazie Blvd. East, Suite 900, Montreal, Quebec, H2M 2P2).

