

Yes! Please enroll me in the Truly Me Insurance Plan for the monthly premium selected below.

PLEASE COMPLETE ALL SECTIONS

1. Personal enrollment information

First Name _____	Preference for Correspondence: <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Last Name _____	Date of Birth <input type="text"/> DD / <input type="text"/> MM / <input type="text"/> YYYY _____
Address _____	Telephone (Home) _____
City <input type="text"/> Street <input type="text"/> Apt. <input type="text"/> Province <input type="text"/> _____	Telephone (Work) _____
Postal Code _____	E-mail address (optional) _____

2. Choose the level of coverage that is convenient for you (Select one option only.)

Your current age	Enhanced Plan \$50,000 total coverage	Basic Plan \$25,000 total coverage
18-25	<input type="checkbox"/> \$11.90	<input type="checkbox"/> \$7.43
26-30	<input type="checkbox"/> \$18.49	<input type="checkbox"/> \$10.72
31-35	<input type="checkbox"/> \$27.66	<input type="checkbox"/> \$15.10
36-40	<input type="checkbox"/> \$37.92	<input type="checkbox"/> \$19.91
41-45	<input type="checkbox"/> \$48.19	<input type="checkbox"/> \$24.74
46-50	<input type="checkbox"/> \$57.83	<input type="checkbox"/> \$29.45
51-55	<input type="checkbox"/> \$86.70	<input type="checkbox"/> \$43.90

This plan includes the Return of Premium Benefit – Provided you have made no claims, all of the premiums you have paid will be returned to you on surrender of this policy after 20 years of continued coverage (should you choose to end the policy) or on your 70th birthday (age of plan expiry), whichever comes first.

3. Declarations and authorizations

I declare that I am a woman between the ages of 18 and 55. **I understand** that my coverage becomes effective the day National Bank Life Insurance Company receives my completed Enrollment Form but my premium is not due for 30 days.

I declare that I have never been diagnosed with a covered female cancer (that is cancer of the breasts, fallopian tubes, cervix, ovaries, uterus, vagina or vulva) or with any other cancer. **I acknowledge** that I have read and understood the terms of the plan coverage including the exclusions on page 2.

I declare that I have not previously been declined for female cancer coverage for reasons other than family history. **I understand** that no benefit is payable if I am diagnosed with a covered female cancer in the first 6 months following the effective date of my policy but in such event, I will receive a full refund of premiums paid.

I acknowledge having read the notice “Access to Personal Information” in section 5 of this Enrollment Form.

I understand that my policy contract, confirming the coverage I have selected, will be sent to me shortly.

I authorize the Insurer to include my name, address and telephone number in its list of clients for business or charitable prospecting by the Insurer or any person to whom it agrees to release this list, and I reserve the right to terminate this authorization at any time by verbal or written request to the Insurer. **I undertake** to inform you immediately, in writing, of any change to my name, address and telephone number so that you can update your files.

I request that my policy contract, including this application, be concluded in English. / *Je demande que le libellé de ma police, y compris la présente proposition, soient établis en anglais.*

I hereby authorize the Insurer to deduct from my account indicated on page 2, each month, all amounts required for the insurance premium under this application.

3. Declarations and authorizations (continued) – Please complete and sign

Pre-authorized Debit Application - Payor's PAD Agreement Personal Business

Withdrawal authorization (frequency and amount of debits): I, the undersigned, authorize the Insurer, its successors, potential transferees or assigns, to carry out, effective immediately, personal pre-authorized debits (PADs) on my account held at the financial institution designated below, on a monthly basis starting with the payment of the initial premium. The date of payment of the initial premium will be indicated in the Summary of Coverage which I will receive when the insurance policy is mailed, subject to approval of my application by the Insurer.

Each withdrawal corresponds to a fixed amount which can be modified, in particular should the withdrawal of the initial premium not be accepted, provided the Insurer sends me a written notice at least 10 days before the deadline of the modified withdrawal.

Waiver: I waive any other confirmation before the first payment. I waive my right to receive notification should the amount of the withdrawal change.

Change or cancellation: I agree to notify the Insurer, at least five days before the next scheduled withdrawal, of any changes to the bank account information or to the date of payment. I also authorize the Insurer to make withdrawals on another account, following my verbal or written instructions. In the case of a joint account, the expression "I" used in this agreement refers to all signatories.

This authorization remains in effect until the Insurer receives notification of any changes or cancellation by me. I may revoke my authorization at any time, subject to providing 30 days notice. I may obtain a sample cancellation form, or further information on my right to cancel a PAD Agreement, at my financial institution or by visiting the Canadian Payments Association website at www.cdnpay.ca. I release the financial institution from any liability if the revocation is not respected, except in the case of gross negligence on its part.

Reimbursement: I have certain recourse rights if a debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Personal PAD Agreement. For more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Consent to the disclosure of information: I agree and understand that the information contained in my pre-authorized debit application will be disclosed to the financial institution, to the extent that such disclosure is directly related to and necessary for the proper application of regulations related to pre-authorized debits.

PAYMENT AUTHORIZATION AND INFORMATION ABOUT THE ACCOUNT

(Select one option only. The payment of your premium will not be processed before 30 days.)

PRE-AUTHORIZED CHEQUING

Name of the Financial Institution where the account is held										Branch Address									
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Transit No.

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Institution No.

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Account No.

IMPORTANT: Attach a personal cheque marked "VOID" to avoid any transcription errors.

PAYEE: National Bank Life Insurance Company, 1100 University, 5th Floor, Montreal, Quebec, H3B 2G7, Telephone: 1-877-871-7500 Fax: 514-394-6604

NATIONAL BANK MASTERCARD ACCOUNT

Card No.

5	2	5	8				
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 Expiry Date

MM	YY
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X Signature

Today's date: DD / MM / YYYY

One policy per person. The Truly Me Insurance Plan is available to residents of Canada only.

4. Exclusions

No benefit will be payable:

- if prior to the date we receive your Enrollment Form for this Policy, you have previously been diagnosed with a Covered Female Cancer or with any other Cancer;
- for any Covered Female Cancer contracted or diagnosed within the first six months following the date we receive your Enrollment Form;
- if you have any signs and/or symptoms and/or medical consultations or tests within six months prior to or following the date we receive your Enrollment Form which subsequently lead to a diagnosis of a Covered Female Cancer, regardless of when the diagnosis is made;
- if you have had an abnormal cervical 'smear' or 'PAP' test result within the last two years prior to the date we receive your Enrollment Form, you will not be covered for Cancer of the cervix until subsequent test results have been normal for a period of two consecutive years;
- for in situ Cancer, that is early Cancer that has not spread to neighbouring tissue;
- if you have failed to follow relevant medical advice which you have received prior to the date we receive your Enrollment Form or which you received during the first six months following the date we receive your Enrollment Form;
- the Surgery Benefit will not be payable:
 - if your stay in the Hospital for Surgery is less than 24 consecutive hours unless the Surgery is for a lumpectomy, mastectomy or breast reconstruction;
 - for diagnostic surgery including Biopsy or Aspiration.

If we deny your claim due to exclusions b), c), d) or f) above, all of your premium will be refunded to you.

5. Access to Personal Information

In order to protect the confidentiality of the personal information that is held on you, National Bank Life Insurance Company shall establish an insurance file in which the information regarding your application for insurance and any claim will be included. Only those employees or agents who are responsible for underwriting, administration, investigation and claims including the reinsurer, or any other person authorized by you, will have access to this file. Your file will be held in the Insurer's office. You will be entitled to have access to the personal information contained in your file, and if appropriate, have it corrected by sending a written request to: National Bank Life Insurance Company, Personal Information Officer, 1100 University Street, 5th Floor, Montreal, Quebec, H3B 2G7.

Questions? Please call us toll-free at 1-877-871-7500.

**Please mail both pages of your Enrollment Form to:
National Bank Life Insurance Company, Customer Service, PO Box 482 Station B, Montreal, QC H3B 3K3**