

**Yes**, I/we wish to enroll in the Guaranteed Acceptance Life Insurance Plan

### PERSONAL ENROLLMENT INFORMATION

#### YOU

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Preference for Correspondence:  Mr.  Mrs.  Ms.

Address: \_\_\_\_\_ Street \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female  
(Day/Month/Year)

SIN: | | | | | | | | | | | | | | | |

( ) ( )

Home Telephone \_\_\_\_\_ Business Telephone \_\_\_\_\_

E-mail Address (optional) \_\_\_\_\_

#### YOUR SPOUSE (IF ENROLLING)

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Preference for Correspondence:  Mr.  Mrs.  Ms.

Date of Birth \_\_\_\_\_  Male  Female  
(Day/Month/Year)

SIN: | | | | | | | | | | | | | | | |

( ) ( )

Home Telephone \_\_\_\_\_ Business Telephone \_\_\_\_\_

E-mail Address (optional) \_\_\_\_\_

### PLEASE COMPLETE ALL SECTIONS

**1. Choose your monthly premium** Select  one option for each insured.

#### YOU

\$75  \$60  \$45  \$30  \$20

#### YOUR SPOUSE (IF ENROLLING)

\$75  \$60  \$45  \$30  \$20

We will send you confirmation of your coverage which is based on your age, gender and the premium level you choose. Within the first two years of your policy, your Basic Benefit is 100% of premiums paid. After two years, the full Basic Benefit as shown in your Benefits Chart is payable. Your Accident Benefit is paid for accidental death occurring any time between the first day of your policy and age 85.

**2. Beneficiary Designation**

#### YOU

I wish to name the following beneficiary:

\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Relationship to the Insured \_\_\_\_\_

Date of Birth \_\_\_\_\_  
(Day/Month/Year)

Revocable  Irrevocable

If your beneficiary is designated as irrevocable, this means that he or she must provide their written approval in the event you wish to change your beneficiary or cancel your insurance policy. Written notice must be sent to the Insurer.  
However, your beneficiary's approval is not required when the designation is revocable.

#### YOUR SPOUSE (IF ENROLLING)

I wish to name the following beneficiary:

\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Relationship to the Insured \_\_\_\_\_

Date of Birth \_\_\_\_\_  
(Day/Month/Year)

Revocable  Irrevocable

If your beneficiary is designated as irrevocable, this means that he or she must provide their written approval in the event you wish to change your beneficiary or cancel your insurance policy. Written notice must be sent to the Insurer.  
However, your beneficiary's approval is not required when the designation is revocable.

### 3. Declarations and authorizations

I **declare** that I am between the ages of 50 and 75 and that the information provided by me on this Acceptance Form and in respect to any insurance issued is true and complete.

I **acknowledge** having read the notice "Access to Personal Information" in section 5 of this form.

I **understand** that my coverage becomes effective the day the company receives this completed Acceptance Form but my premium is not due for 30 days.

I **agree** to be bound by all the provisions of the insurance policy and I authorize the Insurer and National Bank of Canada to use my Social Insurance Number for administrative purposes.

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

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

**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](http://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](http://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.	<table border="1"><tr><td>5</td><td>2</td><td>5</td><td>8</td><td></td><td></td><td></td><td></td></tr></table>	5	2	5	8					<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							Expiry Date	<table border="1"><tr><td>MM</td><td>YY</td></tr></table>	MM	YY
5	2	5	8																	
MM	YY																			

Check here **ONLY** if this policy is intended to replace any life insurance policy presently in effect, in which event you should contact a licensed insurance agent prior to making this decision.

DD	/	MM	/	YYYY
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Your Signature Today's date

DD	/	MM	/	YYYY
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Your Spouse's Signature (if enrolling) Today's date

**One policy per person. The Guaranteed Acceptance Life Insurance Plan is available to residents of Canada.**

### 4. Exclusions

For the Basic coverage, we will not pay the benefit amount for death resulting from a suicide that occurs within the first two years. In this case, all premiums paid will be refunded in full.

For the Accidental Death coverage, we will not pay the benefit amount for death resulting from:

- an injury occurring while committing a criminal act or in a war;
- an injury received while under the influence of alcohol or drugs;
- suicide.

### 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 Acceptance Form to:**

**National Bank Life Insurance Company, Customer Service, PO Box 482 Station B, Montreal, QC H3B 3K3**