

# Juvenile <sup>30/100</sup>



Insurance Application



# JUVENILE 30/100 APPLICATION

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# JUVENILE 30/100 APPLICATION

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## SECTION A - PROPOSED LIFE INSURED

Insured n° 1	Insured n° 2																																
1. Name _____	1. Name _____																																
2. First Name _____	2. First ame _____																																
3. Sex M F      4. DOB <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>	Y	Y	Y	Y	M	M	D	D									3. Sex M F      4. DOB <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>	Y	Y	Y	Y	M	M	D	D								
Y	Y	Y	Y	M	M	D	D																										
Y	Y	Y	Y	M	M	D	D																										
5. Age at nearest anniversary <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td></tr></table>			5. Age at nearest anniversary <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td></tr></table>																														
6. Save Age _____	6. Save Age _____																																
7. Birth Country _____	7. Birth Country _____																																
8. Canadian Citizen      Permanent Resident	8. Canadian Citizen      Permanent Resident																																
American Citizen      TIN _____	American Citizen      TIN _____																																
Other _____	Other _____																																
9. Since when in North America ? _____	9. Since when in North America ? _____																																
10. SIN <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											10. SIN <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																						
11. Current Address _____	11. Current Address _____																																
City _____ Province _____	City _____ Province _____																																
Postal Code <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>							Postal Code <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																										
12. Since ? _____	12. Since ? _____																																

## SECTION B - BENEFICIARY

(Upon the death or following an illness covered under the critical illness protection of the proposed life insured.)

	Beneficiary	Additional	Contingent																																
1. Complete name _____	5. Complete name _____	6. Relationship to the insured _____	7. Date of birth <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>	Y	Y	Y	Y	M	M	D	D																								
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Y	Y	Y	Y	M	M	D	D																												
Y	Y	Y	Y	M	M	D	D																												

\*4. Designation    Revocable                      Irrevocable                      \*8. Designation    Revocable                      Irrevocable

\* Note : In the province of Quebec, in the absence of choice on questions 4 and 8, a spouse or common-law partner designation is irrevocable and any other beneficiary designation is revocable. The contingent beneficiary designation is always revocable.

## SECTION C - OWNER

1. Name \_\_\_\_\_      First Name \_\_\_\_\_      2. SIN 

--	--	--	--	--	--	--	--

3. Sex M F      4. Date of Birth 

Y	Y	Y	Y	M	M	D	D

5. Age \_\_\_\_\_

6. Canadian Citizen      Permanent Resident      American Citizen      TIN \_\_\_\_\_      Other \_\_\_\_\_

7. Current Address \_\_\_\_\_      Postal Code 

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8. Occupation \_\_\_\_\_      9. Employer \_\_\_\_\_

10. Currently Working ? Yes      No      11. Relationship \_\_\_\_\_

12. Civil Status \_\_\_\_\_      13. Birth Country \_\_\_\_\_

14. Telephone 

--	--	--	--	--	--	--	--	--	--

 Cellular      Home      Office 

E	X	T	E	.

15. Contingent Owner    Name \_\_\_\_\_      First Name \_\_\_\_\_



## JUVENILE 30/100 APPLICATION

### SECTION D - EXISTING INSURANCE

**IMPORTANT** 1. Insurance in force    Yes                  No                  If yes, complete the following table :

2. Name/# of the insured	3. Company	4. Month & year issued	5. Type of insurance: <i>Life, Long Term Care or Critical Illness</i>	6. Sum insured

### SECTION E - INSURANCE SPECIFICATIONS

HAVE ANY OF THE PERSONS TO BE INSURED BY THIS APPLICATION:	Insured #1		Insured #2	
	Yes	No	Yes	No
1. Have any Life, Long Term Care or Critical Illness application been declined, modified or cancelled ? (If yes, date, decision, company's name and reason.)				
2. Intend to replace any existing insurance with this one ? (If yes, company's name and complete the « Replacement Notice form ».)				
3. Have one or more applications pending in one or more companies ? (If yes, amount, type of insurance, company's name and will all the policies be settled ?)				

For all affirmative answers, please complete the following table :

# Insured	Quest. n°	Date	Reason	Appropriate details according to the question

### SECTION F - PREMIUM AND PROTECTION

Choice	Premium	Insurance protection
	\$15 / month (\$165 / year)	\$100,000 of Life Insurance and \$10,000 of Critical Illness
	\$30 / month (\$330 / year)	\$250,000 of Life Insurance and \$25,000 of Critical Illness
	\$50 / month (\$550 / year)	\$500,000 of Life Insurance and \$50,000 of Critical Illness
ADDITIONAL ACCIDENTAL FRACTURE'S PROTECTION		
	\$4 / month (\$44 / year)	up to \$5,000 for Accidental Fracture

1. Premium frequency    Annual                  Monthly (P.A.D.)                  2. Premium for the chosen premium frequency    \$ \_\_\_\_\_
3. Preference for monthly withdrawal day \_\_\_\_\_ (1 to 28 inclusive)                  4. Amount paid with application    \$ \_\_\_\_\_





The Insurability Declaration  
contained in the tele-interview are  
an integral part of the contract.

### Tele-interview informations

The tele-interview must be completed by the father, the mother or the legal guardian of the insured.

Email adress \_\_\_\_\_

Telephone

The most appropriate time to contact you ?

During business hours:  Time: \_\_\_\_\_

Out of business hours:  Time: \_\_\_\_\_



**AGREEMENT FOR THE ESTABLISHMENT OF A PERSONAL FILE**

To ensure the confidentiality of your personal information including social insurance number, **UL Mutual** will establish a file for the purpose of providing you with insurance and other financial services. It will contain all information obtained at the time of the application for insurance and of any insurance claim. The object of the file will be to enable **UL Mutual** to assess this application, administer any policy that may be issued and appraise any risk or claim. Only authorized employees will have access to this file. You are entitled to access the personal information in this file and, if applicable, to rectify any inconsistency. To do so, a written request must be sent to **UL Mutual** Head Office at 142, Heriot Street, Drummondville (Quebec) J2C 1J8.

**AUTHORIZATION TO OBTAIN AND RELEASE PERSONAL INFORMATION TO A THIRD PARTY**

In order to assess insurability, maintain our file and claims assessment, we authorize any person or institution holding personal information about us including any health information, medical history or eligibility for claims, to transmit such information to **UL Mutual** or its reinsurers upon request. This includes doctors or other practitioners, hospitals, medical clinics or paramedical companies, laboratories, insurance companies or reinsurers, the MIB Inc., personal information agencies, financial advisors, any financial institutions, the policy owner, your employer or previous employer, the «Commission de santé et sécurité du travail du Québec» or other Workmen’s compensation Board, Canada or Quebec Pension Plan, «Société de l’assurance automobile du Québec» or other Department of Motor Vehicles, the «Régie de l’assurance médicaments du Québec» or other provincial Health Departments, security and investigation agencies, claims and underwriting agencies, crime prevention or detection agencies.

Likewise, we authorize **UL Mutual** to transmit the information to its reinsurers as well as to a third party. For the same purpose and to gather the same type of information, we also authorize **UL Mutual** or its reinsurers to request an investigative report about us and to use information in their possession in other files. This consent is also valid for gathering, use and transmission of personal information concerning our minor children. No modification or alteration of this consent will affect its content nor bind the insurer. This consent may also be used for a request for additional insurance or a contract modification.

**DECLARATION**

We, as the proposed life insured, the father/mother/legal guardian and the policy owner, declare having examined all the questions included in this application. All answers given were correctly reproduced and are complete and true. Also, we authorize that they be used as the basis for the insurance contract requested and we recognize that any false declaration or omission may void the insurance contract issued as a result of this application.

We acknowledge that the insurance will take effect upon acceptance of the application by the Company as long as it was accepted without modification, the first premium has been paid and no change has occurred in the insurability of any of the proposed insured since the signature of this application.

We declare having been notified that the financial advisor is to be paid by commission in relation to the transactions described in this insurance application and that he is an independant worker and not the insurer’s representative.

We acknowledge to have examined the agreement for the establishment of a personal file.

We acknowledge to have read and received the notice of information disclosure.

A photocopy of this agreement shall be as valid as the original.

Note : If the names and first names in sections A and C differ from the following signatures, the latter will appear on the contract.

**I understand that the illnesses covered by this insurance are limited to those described in the contract.**

**I hereby state that I am not an American citizen. However, in the case in which I would be an American citizen, my Taxpayer Identification Number (TIN) can be found section A and C.**

**I have been informed the financial advisor is independent of the insurer and is not its representative.**

**I certify that the statements and answers contained in this application and the telephone interview are complete and true and they are part of my Juvenile 30/100 application and cannot be separated.**

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Signatures : \_\_\_\_\_  
                                Insured #1 (if 14 years or older)                                  Insured #2 (if 14 years or older)                                  Owner (if company, duly appointed representative)  
                                Father/mother or legal guardian                                  Financial Advisor



PRE-AUTHORIZED DEBIT (P.A.D.)

I authorize UL Mutual to issue cheques on my behalf and orders for payment of any nature, drawn from the financial institution hereby designated and payable to UL Mutual to clear the amounts due to UL Mutual for the insurance policy issued following the application identified by the number listed above.

Name of Financial Institution (FI) \_\_\_\_\_
Branch Address \_\_\_\_\_
Type of Account Cheque Saving Type of Service Personal Enterprise
Payment Frequency Monthly Annual Withdrawal Day [ ] Transit Number \_\_\_\_\_ Account Number \_\_\_\_\_

IMPORTANT
Attach a specimen cheque of your
Financial Institution

If this is a joint account where multiples signatures are required, all account holders must sign the authorization.
This authorization stays in force until UL Mutual has received from me a notice of modification or termination. This notice must arrive at least 10 business days before the date on which we debit the account, to the UL Mutual mailing address. I may obtain a cancellation form or more information on my right to cancel a P.A.D. by the payor by communicating with my financial institution or by visiting www.cdnpay.ca. UL Mutual is not allowed to transfer this authorization, directly or indirectly, by application of the law, by a change of control or otherwise, without giving me at least 10 days notice.

I have certain rights of appeal if a debit is not in conformance to the present agreement. For example, I have the right to get reimbursed any P.A.D. which had not been previously approved or is not compatible with the present P.A.D. agreement. To obtain a reimbursement form or for more information on my rights of appeal, I can communicate with my financial institution or visit www.cdnpay.ca.

Please list here all insurance policy numbers issued by UL Mutual or all application numbers submitted that you want to be paid under this authorization. \_\_\_\_\_

Signature of the person whose name appears on the cheques \_\_\_\_\_ Signature of the person whose name appears on the cheques \_\_\_\_\_
Note: If this is a joint account where multiples signatures are required, all account holders must sign the authorization.

AUTHORIZATION - We, the undersigned,

- 1. Acknowledge having read and received the notice of information disclosure.
2. Authorize any doctor, health professional or institution according to the Health and social services legislations, insurance companies, MIB Inc. or any other agency, institution or person in possession of information about us or our health to transmit it to UL Mutual and its reinsurers.
3. Consent that a confidential report, including personal information in relation to our solvency, be requested regarding our request for insurance and we authorize that UL Mutual make a brief report of our personal health information to the MIB Inc.
4. Attest that this authorization remains valid as long as it is not revoked and after our deaths, we consent it to be given, as the case may be, by our heirs, executors or beneficiaries of the insurance policy issued, thereby renouncing in advance to the benefits of any legal disposition concerning professional secret and authorizing any person to transmit all information requested by UL Mutual.
5. We acknowledge that a photocopy of the present authorization shall be as valid as the original.

Signatures : \_\_\_\_\_ Insured #1 (if 14 years or older) \_\_\_\_\_ Insured #2 (if 14 years or older) \_\_\_\_\_ Owner (if company, duly appointed representative)
Father/mother or legal guardian \_\_\_\_\_ Financial Advisor \_\_\_\_\_

AUTHORIZATION - We, the undersigned,

- 1. Acknowledge having read and received the notice of information disclosure.
2. Authorize any doctor, health professional or institution according to the Health and social services legislations, insurance companies, MIB Inc. or any other agency, institution or person in possession of information about us or our health to transmit it to UL Mutual and its reinsurers.
3. Consent that a confidential report, including personal information in relation to our solvency, be requested regarding our request for insurance and we authorize that UL Mutual make a brief report of our personal health information to the MIB Inc.
4. Attest that this authorization remains valid as long as it is not revoked and after our deaths, we consent it to be given, as the case may be, by our heirs, executors or beneficiaries of the insurance policy issued, thereby renouncing in advance to the benefits of any legal disposition concerning professional secret and authorizing any person to transmit all information requested by UL Mutual.
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Signatures : \_\_\_\_\_ Insured #1 (if 14 years or older) \_\_\_\_\_ Insured #2 (if 14 years or older) \_\_\_\_\_ Owner (if company, duly appointed representative)
Father/mother or legal guardian \_\_\_\_\_ Financial Advisor \_\_\_\_\_





CONDITIONAL INTERIM INSURANCE PROVISIONS

Received from \_\_\_\_\_ the amount of \$ \_\_\_\_\_ for an insurance application submitted to UL Mutual and bearing the same number and the same date as this agreement.

Notwithstanding the terms and conditions in the application, if all conditions and restrictions listed below are fully complied with, the Life Insurance and Critical Illness Insurance on the proposed life insured takes effect on the latest of the following dates :

- a) The date of the application
or
b) The date of the last test and/or the last proof of insurability form required by the Company.

CONDITIONS AND LIMITATIONS

- 1. The above mentioned amount must be immediately cashable and must be at least equal to one monthly premium under this application.
2. The cheque to pay this application must be honored the first time it is presented for payment.
3. At the latest of a) or b) above, each proposed life insured must be insurable at standard rate, without extra premium or policy limitations or exclusions according to UL Mutual's normal underwriting rules regarding to proposed policy.
4. The maximum amount of benefits payable under this agreement, any other similar agreement and other insurance in force with the Company is equal to the amount of life insurance or critical illness asked without exceeding a total of \$500,000.
5. Any insurance under this agreement is subject to the terms and conditions of the proposed policy and will cease at the earliest of:
a) The date that the insurance policy applied for is issued,
b) 60 days from the issue date of this agreement,
c) The date that a cancellation notice from the owner is received by the Company.
6. No life insurance or critical illness benefit will be payable under this agreement if the proposed life insured:
a) Is less than 15 days old;
or
b) Has had an application or reinstatement request declined, postponed or accepted with an extra premium or limitation or exclusion at UL Mutual or elsewhere;
or
c) Was hospitalized during more than five (5) days during the last twelve (12) months;
or
d) Has committed suicide, made a false declaration, a non-disclosure or a fraudulent statement in the insurance application;
or
e) Has committed or has intended to commit or has tried to commit a criminal act.
7. Furthermore, no critical illness benefit will be payable if:
a) The insured is diagnosed with cancer, as defined in the policy to be insured;
or
b) The insured is diagnosed with any other condition covered by the policy to be issued and doesn't meet the survival period as defined in the policy.

No representative of the Company is authorized to modify any of the conditions or limitations stated above.

If one or more of the conditions or restrictions stated above are not fully complied with, the sole responsibility of the Company under this agreement is to reimburse all premiums paid by the policy owner.

I have read and signed this agreement and I certify that all requested explanations were given to me by the financial advisor and are to my entire satisfaction.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Signature of financial advisor \_\_\_\_\_ Signature of Owner \_\_\_\_\_

IMPORTANT: Please detach and leave with the client if the above conditions and limitations are fully complied with.



## NOTICE OF INFORMATION DISCLOSURE

Any life insurance request requires a gathering of information that must be as complete as possible. This information is of medical nature or in relation to your solvency.

In order to allow proper risk assessment for each of their insured, most life insurance companies, including **UL Mutual**, deal with an organization named MIB Inc., a non-profit organization which carries out an information exchange on behalf of its member companies.

All information relating to your insurability is treated confidentially. However, **UL Mutual** may transmit it to the MIB Inc.

If you submit a life or critical illness insurance request or if you submit a claim request to a member company, the MIB Inc. will provide that company, at its request, with the information it has on you. If it receives a request from you, the MIB Inc. will make arrangements to provide you with the information in your file. If you doubt the accuracy of the information from the MIB Inc., you may ask for rectification.

Here is the address of the MIB Inc.:

MIB Inc.  
330, University Avenue, suite 501  
Toronto (ON)  
M5G 1R7

You can contact the MIB Inc. at 416-597-0590

Visit [www.mib.com](http://www.mib.com) for more information.

**NOTE TO FINANCIAL ADVISOR** - Remit this notice to the policy owner

### NOTICE

In order to proceed with the analysis of your insurance application, it is possible that we will need to obtain additional information.

#### **Investigation**

A representative from an investigation company may contact you in order to get more personal and financial information.

#### **Medical examination**

A physician or a nurse from a paramedical organization may ask you to undergo a medical examination.

#### **Tests**

A physician or a nurse from a paramedical organization or from a medical clinic may ask for a blood or urine sample. The test will focus on the presence of many possible abnormalities like cholesterol, diabetes, liver problems, the presence of medication, drugs, nicotine and AIDS detection. In order to take a blood or urine sample, your consent will be required.



**WELCOME TO UL MUTUAL  
YOUR MUTUAL LIFE INSURANCE COMPANY**

Thank you for submitting an insurance application with us.

In business since 1889, **UL Mutual** is a century-old mutual life insurance company and its financial strength is legendary. Its success is mainly due to sound business management and its well established distribution network.

When your application is accepted, you will automatically become a **UL Mutual** mutualist, offering you, among others, the following advantages:

- the right to vote at the annual general assembly;
- the right to elect the board of directors.

For all your individual life insurance, commercial insurance and investment needs, the expertise of **UL Mutual** and of your financial advisor is your guarantee of quality service.

A handwritten signature in black ink, reading 'Alexandre Desbiens', written over a horizontal line.

**Alexandre Desbiens, ASA, AICA, FRM, PRM**  
Vice-President - Sales and Marketing  
Individual Insurance, Investment and Retirement

Telephone : 1-800-567-0988

UL Mutual is a member of Assuris.

Assuris is a non-profit organization that protects Canadian policyholders in the event that their life insurance company should become insolvent.

125

years of commitments  
meant to create wealth  
and protect what really  
matters.

[ulmutual.ca](http://ulmutual.ca)

142, Heriot , C.P. 696, Drummondville (QC) J2B 6W9

Telephone: 819-478-1315

Fax: 819-474-1990

Toll free : 1-800-567-0988