securian CANADA

Customer Service: 1-888-307-7443

Insurance Application
Plan STQ251

Canadian Premier Life Insurance Company (Securian Canada), hereinafter "we", provides the insurance described in certificate number:	STQ -	Effective Date of Insurance

Financing Agreement: ☐ Purchase (loan) ☐ Lease

A) Financing agreement information

Term (in months)	Interest Rate	Monthly Payment (excluding insurance premium)	Total Amount Financed (excluding insurance premium)
months	%	$	$

B) Applicant 1 Information

Last Name	First Name	Phone Number	Date of Birth	Sex

Number	Street	Apt.	City	Province	Postal Code

C) Applicant 2 Information

Last Name	First Name	Phone Number	Date of Birth	Sex

Number	Street	Apt.	City	Province	Postal Code

D) Distributor Information

Name

Number	Street	Suite	City	Province	Postal Code

E) Financing Agreement Creditor Information

Name

Number	Street	Suite	City	Province	Postal Code

F) Insurance Coverages

NOTE: This insurance is optional and is not required for the financing agreement. The insurance can be terminated at any time with a written notice.

		Applicant 1	Applicant2	Insurance Premium	Coverage End Date	Coverage Term (in months)
Life Insurance Coverage*	**Initial Benefit**	$	$	$		months
	Residual Value	$	$			
Disability Insurance Coverage	**Monthly Benefit**	$	$	$		months

Waiting Period	Selected Option	and	Benefit Period	Selected Option
30 days (non-retroactive)	☐		12 months**	☐
30 days (retroactive)	☐		18 months**	☐
			Insurance Term	☐

* Accidental dismemberment insurance is automatically included when you purchase life insurance.
** The number of benefits paid is limited to this total duration, whether or not benefits were consecutive, and applies cumulatively to all your total disabilities, if applicable. Also, **12 and 18-month options** are not available on contracts financed by Ford Credit.

Subtotal	$
Taxes	$
Total	$

G) Effective Date of Insurance

Your insurance takes effect on the latest of the following dates: 1) the date on which this insurance application is signed, 2) if a medical questionnaire is required, the date on which we approve your insurance application, 3) the date on which the loan is disbursed in whole or in part, as long as the disbursement is made in the 90 days after the insurance application is signed. After this time, a new insurance application must be submitted.
If you must complete a medical questionnaire (see section **H) Required Medical Questionnaire** of this insurance application), you will be temporarily covered for the period during which we analyze your application, up to 90 days. After this time, a new insurance application must be submitted.
If you fail to satisfy the eligibility criteria, insurance will not be granted and all premiums paid will be reimbursed to the creditor.

H) Required Medical Questionnaire

Applicants have to complete a medical questionnaire in the following situations:

1. For **life insurance** coverage:	When the initial benefit amount exceeds $100,000.

2. When the insurance application is submitted after the financing agreement is signed, regardless of the insurance amount or the applicant's age.

Please read and answer all the questions carefully. Subject to the temporary insurance and other terms and conditions, insurance will not take effect until we have analyzed and approved your insurance application. If your application is denied, the denial will apply to the denied coverage(s) **only**.

I) General eligibility criteria *(applicable to all insurance coverages)*

To be eligible for the insurance offered in this application, the following conditions must be met:

1. Be a natural person; and
2. Be a Canadian resident; and
3. Be the lessee(s) (as indicated in the lease agreement) or the borrower(s) (as indicated in the loan agreement) or the surety.

J) Additional eligibility criteria applicable to the life insurance coverage

In addition to the conditions stipulated in section I) General eligibility criteria**, the following conditions must be met.** On the effective date of insurance, you must respect the minimum age, maximum age, maximum insurable amount, and maximum term requirements stipulated below:

Age	Maximum Insurable Amount	Maximum Term
Age 16 and under	*Life insurance is not available.*	
Age 17 to 67	$125,000	108 months
Age 68 and over	*Life insurance is not available.*	

K) Additional eligibility criteria applicable to the disability insurance coverage

In addition to the conditions stipulated in section I) General eligibility criteria**, the following conditions must be met**:

i) On the effective date of insurance, you must respect the minimum age, maximum age, maximum insurable amount, and maximum term requirements stipulated below:

Age	Maximum Insurable Amount	Maximum Term
Age 16 and under	*Disability insurance is not available.*	
Age 17 to 64	$2,000*	108 months
Age 65 and over	*Disability insurance is not available.*	

* For seasonal workers, the maximum insurable amount is limited to $1,000 per month.

ii) You must satisfy the requirements stipulated in section **L) Other eligibility criteria** in this insurance application.

L) Other eligibility criteria *(applicable to the disability insurance coverage)*

1. If you are on **maternity, paternity or parental leave or pregnant (or breastfeeding) on preventive leave**, the following conditions must be met:
   - i) In the 12 months prior to the start of your leave or preventive leave, you satisfied the **definition of actively at work**; and
   - ii) Were it not for your leave or preventive leave, you would have been apt to carry out the normal tasks of the occupation you had prior to your leave or preventive leave when you completed this insurance application.
2. If you are a **seasonal worker**, the following conditions must be met:
   - i) For the last 24 months, you have worked in the same industry; and
   - ii) Over the last 12 months, you have worked more than 10 consecutive weeks during which you worked at least 25 hours per week; and
   - iii) Over the last 12 months, you received regular Employment Insurance (EI) benefits or EI fishing benefits; and
   - iv) When completing this insurance application, you were apt to carry out the normal tasks of your occupation.
3. If you are **self-employed or an entrepreneur**, the following conditions must be met:
   - i) For the last 12 months, you satisfied the **definition of actively at work**; and
   - ii) For the last 12 months, you have worked for the same company; and
   - iii) Over the last completed fiscal year, the annual income of your company is at least $10,000, after deduction of all operating expenses; and
   - iv) When completing this insurance application, you were apt to carry out the normal tasks of your occupation.
4. If situations 1 to 3 do not apply to you, the following conditions must be met:
   - i) For the last 12 months, you satisfied the **definition of actively at work**; and
   - ii) When completing this insurance application, you were apt to carry out the normal tasks of your occupation.

Definition of Actively at Work

Your employment requires you to work a minimum of:

- 25 hours per week; and
- 35 weeks (consecutive or not) per year, excluding all periods during which you are not at work (e.g., unpaid leave, sick leave, disability leave).

M) Waivers

I hereby certify that I was presented with an insurance offer, but, after careful consideration, I have decided to refuse:	Applicant 1	Applicant 2
i) Life insurance coverage (including accidental dismemberment coverage)	☐	☐
ii) Disability insurance coverage	☐	☐

N) Declarations

I hereby declare the following:	Applicant 1	Applicant 2
i) The information provided here is factual and complete and any misrepresentation or incompleteness may void the insurance.		
ii) I acknowledge receipt of a copy of the insurance application and insurance certificate.		
iii) I have read and understood the provisions, definitions and exclusions in the insurance certificate.		
iv) I understand that any benefits payable under this insurance are payable solely to the creditor to reimburse the financing agreement in whole or in part.		
v) Upon receipt of the insurance offer, the distributor gave me a Summary and a Fact sheet.		
vi) I authorize the distributor to pay the insurer the total premium on my behalf. If my insurance application is denied, the insurer's responsibility is limited to reimbursing the premium.		
vii) This insurance application, medical questionnaire (if applicable) and all forms submitted make up the insurance certificate.		
viii) I have read, understand and agree with the contents of the section **File and Personal Information** below: **File and Personal Information:** Respecting your privacy is a priority for Canadian Premier Life Insurance Company. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit http://www.securiancanada.ca/privacy-statement.	☐	☐
ix) I authorize any healthcare or rehabilitation provider, other insurance or reinsurance companies, any person having knowledge of me or my health and our service providers to exchange personal information, when relevant and necessary for the purposes of processing my application, managing the insurance and assessing claims. I also authorize the exchange of personal information with the creditor for the purpose of managing this insurance.		
x) I confirm that a photocopy or electronic copy of this authorization is as valid as the original.		
xi) **I acknowledge that my benefit claim could be denied if it is related to a pre-existing medical condition, as defined below, if the event that is the subject of the benefit claim occurs in the 18 months following the effective date of insurance.** A **pre-existing medical condition** is any health problem that includes, but is not limited to, an illness, a critical illness, an injury or any other affliction, like a psychological, nervous or psychiatric disorder, for which, in the 12 months prior to the effective date of insurance: - You received a treatment stipulated in the **List of treatments**; or - You had symptoms that would lead a reasonably cautious person to seek a diagnosis, care or treatment. **List of treatments:** - a diagnosis - a medical opinion - a treatment - a service - a prescription drug - a consultation, including a consultation for investigation.	☐	☐

Signature - Applicant 1 | Date of signature | Signature - Applicant 2 | Date of signature

Distributor's authorized signature | Date of signature

INSURER'S COPY

securian CANADA

Customer Service: 1-888-307-7443

Insurance Application
Plan STQ251

Canadian Premier Life Insurance Company (Securian Canada), hereinafter "we", provides the insurance described in certificate number:	STQ -	Effective Date of Insurance

Financing Agreement: ☐ Purchase (loan) ☐ Lease

A) Financing agreement information

Term (in months)	Interest Rate	Monthly Payment (excluding insurance premium)	Total Amount Financed (excluding insurance premium)
months	%	$	$

B) Applicant 1 Information

Last Name	First Name	Phone Number	Date of Birth	Sex

Number	Street	Apt.	City	Province	Postal Code

C) Applicant 2 Information

Last Name	First Name	Phone Number	Date of Birth	Sex

Number	Street	Apt.	City	Province	Postal Code

D) Distributor Information

Name

Number	Street	Suite	City	Province	Postal Code

E) Financing Agreement Creditor Information

Name

Number	Street	Suite	City	Province	Postal Code

F) Insurance Coverages

NOTE: This insurance is optional and is not required for the financing agreement. The insurance can be terminated at any time with a written notice.

		Applicant 1	Applicant2	Insurance Premium	Coverage End Date	Coverage Term (in months)
Life Insurance Coverage*	**Initial Benefit**	$	$	$		months
	Residual Value	$	$			
Disability Insurance Coverage	**Monthly Benefit**	$	$	$		months

Waiting Period	Selected Option	and	Benefit Period	Selected Option
30 days (non-retroactive)	☐		12 months**	☐
30 days (retroactive)	☐		18 months**	☐
			Insurance Term	☐

* Accidental dismemberment insurance is automatically included when you purchase life insurance.
** The number of benefits paid is limited to this total duration, whether or not benefits were consecutive, and applies cumulatively to all your total disabilities, if applicable. Also, **12 and 18-month options** are not available on contracts financed by Ford Credit.

Subtotal	$
Taxes	$
Total	$

G) Effective Date of Insurance

Your insurance takes effect on the latest of the following dates: 1) the date on which this insurance application is signed, 2) if a medical questionnaire is required, the date on which we approve your insurance application, 3) the date on which the loan is disbursed in whole or in part, as long as the disbursement is made in the 90 days after the insurance application is signed. After this time, a new insurance application must be submitted.
If you must complete a medical questionnaire (see section **H) Required Medical Questionnaire** of this insurance application), you will be temporarily covered for the period during which we analyze your application, up to 90 days. After this time, a new insurance application must be submitted.
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H) Required Medical Questionnaire

Applicants have to complete a medical questionnaire in the following situations:

1. For **life insurance** coverage:	When the initial benefit amount exceeds $100,000.

2. When the insurance application is submitted after the financing agreement is signed, regardless of the insurance amount or the applicant's age.

Please read and answer all the questions carefully. Subject to the temporary insurance and other terms and conditions, insurance will not take effect until we have analyzed and approved your insurance application. If your application is denied, the denial will apply to the denied coverage(s) **only**.

I) General eligibility criteria *(applicable to all insurance coverages)*

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1. Be a natural person; and
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J) Additional eligibility criteria applicable to the life insurance coverage

In addition to the conditions stipulated in section I) General eligibility criteria**, the following conditions must be met.** On the effective date of insurance, you must respect the minimum age, maximum age, maximum insurable amount, and maximum term requirements stipulated below:

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K) Additional eligibility criteria applicable to the disability insurance coverage

In addition to the conditions stipulated in section I) General eligibility criteria**, the following conditions must be met**:

i) On the effective date of insurance, you must respect the minimum age, maximum age, maximum insurable amount, and maximum term requirements stipulated below:

Age	Maximum Insurable Amount	Maximum Term
Age 16 and under	*Disability insurance is not available.*	
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* For seasonal workers, the maximum insurable amount is limited to $1,000 per month.

ii) You must satisfy the requirements stipulated in section **L) Other eligibility criteria** in this insurance application.

L) Other eligibility criteria *(applicable to the disability insurance coverage)*

1. If you are on **maternity, paternity or parental leave or pregnant (or breastfeeding) on preventive leave**, the following conditions must be met:
   - i) In the 12 months prior to the start of your leave or preventive leave, you satisfied the **definition of actively at work**; and
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   - i) For the last 24 months, you have worked in the same industry; and
   - ii) Over the last 12 months, you have worked more than 10 consecutive weeks during which you worked at least 25 hours per week; and
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- 25 hours per week; and
- 35 weeks (consecutive or not) per year, excluding all periods during which you are not at work (e.g., unpaid leave, sick leave, disability leave).

M) Waivers

I hereby certify that I was presented with an insurance offer, but, after careful consideration, I have decided to refuse:	Applicant 1	Applicant 2
i) Life insurance coverage (including accidental dismemberment coverage)	☐	☐
ii) Disability insurance coverage	☐	☐

N) Declarations

I hereby declare the following:	Applicant 1	Applicant 2
i) The information provided here is factual and complete and any misrepresentation or incompleteness may void the insurance.		
ii) I acknowledge receipt of a copy of the insurance application and insurance certificate.		
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vii) This insurance application, medical questionnaire (if applicable) and all forms submitted make up the insurance certificate.		
viii) I have read, understand and agree with the contents of the section **File and Personal Information** below: **File and Personal Information:** Respecting your privacy is a priority for Canadian Premier Life Insurance Company. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit http://www.securiancanada.ca/privacy-statement.	☐	☐
ix) I authorize any healthcare or rehabilitation provider, other insurance or reinsurance companies, any person having knowledge of me or my health and our service providers to exchange personal information, when relevant and necessary for the purposes of processing my application, managing the insurance and assessing claims. I also authorize the exchange of personal information with the creditor for the purpose of managing this insurance.		
x) I confirm that a photocopy or electronic copy of this authorization is as valid as the original.		
xi) **I acknowledge that my benefit claim could be denied if it is related to a pre-existing medical condition, as defined below, if the event that is the subject of the benefit claim occurs in the 18 months following the effective date of insurance.** A **pre-existing medical condition** is any health problem that includes, but is not limited to, an illness, a critical illness, an injury or any other affliction, like a psychological, nervous or psychiatric disorder, for which, in the 12 months prior to the effective date of insurance: - You received a treatment stipulated in the **List of treatments**; or - You had symptoms that would lead a reasonably cautious person to seek a diagnosis, care or treatment. **List of treatments:** - a diagnosis - a medical opinion - a treatment - a service - a prescription drug - a consultation, including a consultation for investigation.	☐	☐

Signature - Applicant 1 _____ Date of signature _____ Signature - Applicant 2 _____ Date of signature _____

Distributor's authorized signature _____ Date of signature _____

CLIENT'S COPY

securian CANADA

Customer Service: 1-888-307-7443

Insurance Application
Plan STQ251

Canadian Premier Life Insurance Company (Securian Canada), hereinafter "we", provides the insurance described in certificate number:	STQ -	Effective Date of Insurance

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Name

Number	Street	Suite	City	Province	Postal Code

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L) Other eligibility criteria *(applicable to the disability insurance coverage)*

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M) Waivers

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i) Life insurance coverage (including accidental dismemberment coverage)	☐	☐
ii) Disability insurance coverage	☐	☐

N) Declarations

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vii) This insurance application, medical questionnaire (if applicable) and all forms submitted make up the insurance certificate.		
viii) I have read, understand and agree with the contents of the section **File and Personal Information** below: **File and Personal Information:** Respecting your privacy is a priority for Canadian Premier Life Insurance Company. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit http://www.securiancanada.ca/privacy-statement.	☐	☐
ix) I authorize any healthcare or rehabilitation provider, other insurance or reinsurance companies, any person having knowledge of me or my health and our service providers to exchange personal information, when relevant and necessary for the purposes of processing my application, managing the insurance and assessing claims. I also authorize the exchange of personal information with the creditor for the purpose of managing this insurance.		
x) I confirm that a photocopy or electronic copy of this authorization is as valid as the original.		
xi) **I acknowledge that my benefit claim could be denied if it is related to a pre-existing medical condition, as defined below, if the event that is the subject of the benefit claim occurs in the 18 months following the effective date of insurance.** A **pre-existing medical condition** is any health problem that includes, but is not limited to, an illness, a critical illness, an injury or any other affliction, like a psychological, nervous or psychiatric disorder, for which, in the 12 months prior to the effective date of insurance: - You received a treatment stipulated in the **List of treatments**; or - You had symptoms that would lead a reasonably cautious person to seek a diagnosis, care or treatment. **List of treatments:** - a diagnosis - a medical opinion - a treatment - a service - a prescription drug - a consultation, including a consultation for investigation.	☐	☐

Signature - Applicant 1 _____ Date of signature _____ Signature - Applicant 2 _____ Date of signature _____

Distributor's authorized signature _____ Date of signature _____

securian CANADA

Customer Service: 1-888-307-7443

Insurance Application
Plan STQ251

Canadian Premier Life Insurance Company (Securian Canada), hereinafter "we", provides the insurance described in certificate number:	STQ -	Effective Date of Insurance

Financing Agreement: ☐ Purchase (loan) ☐ Lease

A) Financing agreement information

Term (in months)	Interest Rate	Monthly Payment (excluding insurance premium)	Total Amount Financed (excluding insurance premium)
months	%	$	$

B) Applicant 1 Information

Last Name	First Name	Phone Number	Date of Birth	Sex

Number	Street	Apt.	City	Province	Postal Code

C) Applicant 2 Information

Last Name	First Name	Phone Number	Date of Birth	Sex

Number	Street	Apt.	City	Province	Postal Code

D) Distributor Information

Name

Number	Street	Suite	City	Province	Postal Code

E) Financing Agreement Creditor Information

Name

Number	Street	Suite	City	Province	Postal Code

F) Insurance Coverages

NOTE: This insurance is optional and is not required for the financing agreement. The insurance can be terminated at any time with a written notice.

		Applicant 1	Applicant2	Insurance Premium	Coverage End Date	Coverage Term (in months)
Life Insurance Coverage*	**Initial Benefit**	$	$	$		months
	Residual Value	$	$			
Disability Insurance Coverage	**Monthly Benefit**	$	$	$		months

Waiting Period	Selected Option	and	Benefit Period	Selected Option
30 days (non-retroactive)	☐		12 months**	☐
30 days (retroactive)	☐		18 months**	☐
			Insurance Term	☐

* Accidental dismemberment insurance is automatically included when you purchase life insurance.
** The number of benefits paid is limited to this total duration, whether or not benefits were consecutive, and applies cumulatively to all your total disabilities, if applicable. Also, **12 and 18-month options** are not available on contracts financed by Ford Credit.

Subtotal	$
Taxes	$
Total	$

G) Effective Date of Insurance

Your insurance takes effect on the latest of the following dates: 1) the date on which this insurance application is signed, 2) if a medical questionnaire is required, the date on which we approve your insurance application, 3) the date on which the loan is disbursed in whole or in part, as long as the disbursement is made in the 90 days after the insurance application is signed. After this time, a new insurance application must be submitted.
If you must complete a medical questionnaire (see section **H) Required Medical Questionnaire** of this insurance application), you will be temporarily covered for the period during which we analyze your application, up to 90 days. After this time, a new insurance application must be submitted.
If you fail to satisfy the eligibility criteria, insurance will not be granted and all premiums paid will be reimbursed to the creditor.

H) Required Medical Questionnaire

Applicants have to complete a medical questionnaire in the following situations:

1. For **life insurance** coverage:	When the initial benefit amount exceeds $100,000.

2. When the insurance application is submitted after the financing agreement is signed, regardless of the insurance amount or the applicant's age.

Please read and answer all the questions carefully. Subject to the temporary insurance and other terms and conditions, insurance will not take effect until we have analyzed and approved your insurance application. If your application is denied, the denial will apply to the denied coverage(s) **only**.

I) General eligibility criteria *(applicable to all insurance coverages)*

To be eligible for the insurance offered in this application, the following conditions must be met:

1. Be a natural person; and
2. Be a Canadian resident; and
3. Be the lessee(s) (as indicated in the lease agreement) or the borrower(s) (as indicated in the loan agreement) or the surety.

J) Additional eligibility criteria applicable to the life insurance coverage

In addition to the conditions stipulated in section I) General eligibility criteria**, the following conditions must be met.** On the effective date of insurance, you must respect the minimum age, maximum age, maximum insurable amount, and maximum term requirements stipulated below:

Age	Maximum Insurable Amount	Maximum Term
Age 16 and under	*Life insurance is not available.*	
Age 17 to 67	$125,000	108 months
Age 68 and over	*Life insurance is not available.*	

K) Additional eligibility criteria applicable to the disability insurance coverage

In addition to the conditions stipulated in section I) General eligibility criteria**, the following conditions must be met**:

i) On the effective date of insurance, you must respect the minimum age, maximum age, maximum insurable amount, and maximum term requirements stipulated below:

Age	Maximum Insurable Amount	Maximum Term
Age 16 and under	*Disability insurance is not available.*	
Age 17 to 64	$2,000*	108 months
Age 65 and over	*Disability insurance is not available.*	

* For seasonal workers, the maximum insurable amount is limited to $1,000 per month.

ii) You must satisfy the requirements stipulated in section **L) Other eligibility criteria** in this insurance application.

L) Other eligibility criteria *(applicable to the disability insurance coverage)*

1. If you are on **maternity, paternity or parental leave or pregnant (or breastfeeding) on preventive leave**, the following conditions must be met:
   - i) In the 12 months prior to the start of your leave or preventive leave, you satisfied the **definition of actively at work**; and
   - ii) Were it not for your leave or preventive leave, you would have been apt to carry out the normal tasks of the occupation you had prior to your leave or preventive leave when you completed this insurance application.
2. If you are a **seasonal worker**, the following conditions must be met:
   - i) For the last 24 months, you have worked in the same industry; and
   - ii) Over the last 12 months, you have worked more than 10 consecutive weeks during which you worked at least 25 hours per week; and
   - iii) Over the last 12 months, you received regular Employment Insurance (EI) benefits or EI fishing benefits; and
   - iv) When completing this insurance application, you were apt to carry out the normal tasks of your occupation.
3. If you are **self-employed or an entrepreneur**, the following conditions must be met:
   - i) For the last 12 months, you satisfied the **definition of actively at work**; and
   - ii) For the last 12 months, you have worked for the same company; and
   - iii) Over the last completed fiscal year, the annual income of your company is at least $10,000, after deduction of all operating expenses; and
   - iv) When completing this insurance application, you were apt to carry out the normal tasks of your occupation.
4. If situations 1 to 3 do not apply to you, the following conditions must be met:
   - i) For the last 12 months, you satisfied the **definition of actively at work**; and
   - ii) When completing this insurance application, you were apt to carry out the normal tasks of your occupation.

Definition of Actively at Work

Your employment requires you to work a minimum of:

- 25 hours per week; and
- 35 weeks (consecutive or not) per year, excluding all periods during which you are not at work (e.g., unpaid leave, sick leave, disability leave).

M) Waivers

I hereby certify that I was presented with an insurance offer, but, after careful consideration, I have decided to refuse:	Applicant 1	Applicant 2
i) Life insurance coverage (including accidental dismemberment coverage)	☐	☐
ii) Disability insurance coverage	☐	☐

N) Declarations

I hereby declare the following:	Applicant 1	Applicant 2
i) The information provided here is factual and complete and any misrepresentation or incompleteness may void the insurance.		
ii) I acknowledge receipt of a copy of the insurance application and insurance certificate.		
iii) I have read and understood the provisions, definitions and exclusions in the insurance certificate.		
iv) I understand that any benefits payable under this insurance are payable solely to the creditor to reimburse the financing agreement in whole or in part.		
v) Upon receipt of the insurance offer, the distributor gave me a Summary and a Fact sheet.		
vi) I authorize the distributor to pay the insurer the total premium on my behalf. If my insurance application is denied, the insurer's responsibility is limited to reimbursing the premium.		
vii) This insurance application, medical questionnaire (if applicable) and all forms submitted make up the insurance certificate.		
viii) I have read, understand and agree with the contents of the section **File and Personal Information** below: **File and Personal Information:** Respecting your privacy is a priority for Canadian Premier Life Insurance Company. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit http://www.securiancanada.ca/privacy-statement.	☐	☐
ix) I authorize any healthcare or rehabilitation provider, other insurance or reinsurance companies, any person having knowledge of me or my health and our service providers to exchange personal information, when relevant and necessary for the purposes of processing my application, managing the insurance and assessing claims. I also authorize the exchange of personal information with the creditor for the purpose of managing this insurance.		
x) I confirm that a photocopy or electronic copy of this authorization is as valid as the original.		
xi) **I acknowledge that my benefit claim could be denied if it is related to a pre-existing medical condition, as defined below, if the event that is the subject of the benefit claim occurs in the 18 months following the effective date of insurance.** A **pre-existing medical condition** is any health problem that includes, but is not limited to, an illness, a critical illness, an injury or any other affliction, like a psychological, nervous or psychiatric disorder, for which, in the 12 months prior to the effective date of insurance: - You received a treatment stipulated in the **List of treatments**; or - You had symptoms that would lead a reasonably cautious person to seek a diagnosis, care or treatment. **List of treatments:** - a diagnosis - a medical opinion - a treatment - a service - a prescription drug - a consultation, including a consultation for investigation.	☐	☐

Signature - Applicant 1 | Date of signature | Signature - Applicant 2 | Date of signature

Distributor's authorized signature | Date of signature

DISTRIBUTOR'S COPY

Insurance Certificate
Group Credit Insurance - Plan STQ251

This document is a standard contract for *our* group credit insurance product. Some insurance coverages may not apply to *your* situation. To know the coverages and amounts applicable to the insurance *you* purchased, refer to *your Insurance Application*.

For the purposes of this contract:

- "We", "our(s)" and "us": refers to the insurer of this policy, namely, Canadian Premier Life Insurance Company (Securian Canada), a company whose head office is located at 25 Sheppard Ave Ave West, Suite 1400, Toronto, Ontario, M2N 6S6;
- "You", "your" and "yours": refers, whether individually or collectively, to the insured person(s) named in the *Insurance Application*.

Moreover, the definitions of terms, words and expressions appear in the **Definitions** section under **PART 5 - GENERAL PROVISIONS**, as well as in the **Definitions** sections of each insurance coverage.

These terms, words or expressions are *italicized*.

We only insure *you f*or the coverage(s) described in this certificate if:

- A premium and insurance amount are stipulated in the *Insurance Application*; and
- The insurance premium was paid in full; and
- *We* accepted *your Insurance Application*, after analyzing *your* medical questionnaire, if applicable.

Your certificate is not assignable to whomever, for whatever reason.

Table of contents

Eligibility criteria

To be eligible for the coverages stipulated in this insurance certificate, *you* must satisfy the eligibility criteria in sections I) to L) of the *Insurance Application*.

Part 1 – Life insurance coverage*

* Accidental dismemberment insurance is automatically included when *you* purchased life insurance.

Section 1 – Purpose of coverage

Subject to the other provisions of this certificate, *we* agree to pay an insurance benefit if *you* die while this insurance coverage is in effect.

Section 2 – Amount of insurance benefits

The benefit is payable to the *creditor* named in *your Insurance Application*, upon receipt of satisfactory proof of death.

The amount of the benefit is equal to the lesser of the following amounts:

1. **For a loan agreement**, the balance of the contract owed on the date of *your* death as stipulated in the notice issued by the *creditor*;
2. **For a lease agreement**, the present value of future payments remaining upon the date of *your* death and, if *you* opted for this option, the *residual value* indicated in *your Insurance Application*;
3. The initial benefit stipulated in section **F) Insurance Coverages** of *your Insurance Application*;
4. The maximum insurable amount stipulated in section **J) Additional eligibility criteria applicable to the life insurance coverage** in *your Insurance Application*.

In all cases, the amount of the benefit includes the insurance premium.

Section 3 – Restrictions

1. When more than one person is insured by this insurance coverage, no more than one benefit is payable, to whomever submitted the benefit claims form first.
2. The insurance benefit in no way covers payments in arrears under the *financing agreement* or any accrued interest thereon.

Section 4 – Exclusion

In addition to the exclusions stipulated in **Section 2 – Exclusions** under **PART 5 – GENERAL PROVISIONS** herein, no benefit is payable if the cause of death is suicide in the two years following the *effective date of insurance*.

Part 2 – Disability insurance coverage

Section 1 – Purpose of coverage

Subject to the provisions of this certificate, *we* agree to pay benefits if *you* become *totally disabled* while insured under this coverage and *your total disability* continues after the *waiting period*.

Section 2 – Definitions specific to disability insurance coverage

- "Benefit Period" means the period during which insurance benefits under this insurance coverage are paid. The *benefit period* begins on the day following the end of the *waiting period* and continues until the dates stipulated under **Section – 8 - Termination of benefit payments** herein. (In the event of a retroactive *waiting period*, this period begins on the first day of *total disability*.)

  Your benefit period is stipulated in the "Waiting Period and Benefit Period" paragraph in section **F) Insurance Coverages** of *your Insurance Application*.

- "Recurring Total Disability" means:
  1. Successive periods of *total disability* as a result of the **same causes** and separated by less than 3 complete and consecutive months during which:
     a) *you* returned to work on a daily schedule equivalent to the one *you* had prior to the *total disability*; or
     b) *you* would have been able to return to work.
  2. Successive periods of *total disability* as a result of **entirely different causes** and separated by less than 7 complete and consecutive days during which:
     a) *you* returned to work on a daily schedule equivalent to the one *you* had prior to the *total disability*; or
     b) *you* would have been able to return to work.
- "Replacement Occupation" means occupation for which *you* are reasonably qualified, specifically in terms of *your* training and experience, regardless of its availability.
- "Total Disability" (or "totally disabled"):
  1. If *you* were gainfully employed prior to *total disability*:
     a) In the first 12 months following the start of *total disability*, *you* are considered *totally disabled*, if as a result of *illness* or *accident*:
        i. *you* are incapable of carrying out the most important tasks of *your usual occupation*; and
        ii. *you* are not carrying out any other gainful occupation; and
        iii. *you* are receiving constant medical care from a *physician*.
     b) After 12 months of *total disability*, *you* continue to satisfy the definition of *total disability* if:
        i. *you* are incapable of carrying out a *replacement occupation*; and
        ii. *you* are not carrying out any other gainful occupation; and
        iii. *you* are still receiving constant medical care from a *physician*.
  2. If at the time of *total disability you* are not gainfully employed or on maternity, paternity or parental leave, or on unpaid leave as agreed with *your* employer, *you* are considered *totally disabled*, if as a result of *illness* or *accident*:
     a) *you* are incapable of carrying out a *replacement occupation* because of *your total disability*; and
     b) *you* are not carrying out any other gainful occupation; and
     c) *you* are still receiving constant medical care from a *physician*.

     Uncomplicated pregnancy or uncomplicated childbirth are not considered as a *total disability*.
- "Usual occupation" means the occupation *you* were carrying out immediately before *your total disability*.

- "Waiting period" means the number of consecutive days during which no benefit is paid and that starts when *your total disability* is diagnosed by a *physician*.

  No *waiting period* applies in the event of a *recurring total disability*.

  Your waiting period is stipulated in the "Waiting Period and Benefit Period" paragraph in section **F) Insurance Coverages** of *your Insurance Application*.

Section 3 – Conditions for benefit payments

Benefits will be paid to the *creditor* named in *your Insurance Application* the day after the end of the *waiting period*, if applicable, provided the following conditions are met:

1. *you* are *totally disabled*; and
2. *your total disability* began while this disability insurance coverage was in effect and continued beyond the *waiting period*.

To make it easier to process *your* benefit claim, *we* ask that *you* provide satisfactory proof of *total disability* by no later than 90 days following the onset of *total disability*, as well as any satisfactory medical proof.

Section 4 – Amount of insurance benefits

For each month of *total disability*, a benefit amount is equal to the lesser of the following amounts:

1. the monthly benefit stipulated in section **F) Insurance Coverages** of *your Insurance Application*; or
2. the amount of the monthly payments payable to the *creditor* named in *your Insurance Application* based on *your financing agreement*, excluding any lump sum or *residual value* payment; or
3. the maximum insurable amount stipulated in section **K) Additional eligibility criteria applicable to the disability insurance coverage** of *your Insurance Application*.

In all cases, the amount of the benefit includes the insurance premium.

Furthermore, in the event of *recurring total disability*, the 12 month period stipulated in paragraph a) of the definition of *total disability* above does not start over, but is the continuation of the previous *total disability(ies)*, when applicable.

Benefits are paid monthly to the *creditor* named in *your Insurance Application* at every payment date stipulated in *your financing agreement*, throughout *your total disability*, without exceeding the *benefit period*.

Benefits paid over a period of less than 30 days are calculated at a daily rate corresponding to one-thirtieth (1/30) of the monthly benefit.

Section 5 – Presumptive disability

If, as a result of *illness* or *accident*, *you* suffer:

- **two losses** from the following:
  - Loss of use of a hand
  - Loss of use of a foot
  - Loss of a hand and wrist joint after amputation
  - Loss of foot and ankle joint after amputation

  OR
- **one loss** from the following:
  - Loss of vision in both eyes (a visual acuity of 20/200 or less, or field of vision of less than 20 degrees)
  - Loss of speech for a period of at least 6 consecutive months
  - Loss of hearing in both ears, with a hearing threshold of more than 90 decibels

you will be considered *totally disabled,* regardless of whether *you* were employed at the time of the loss and whether or not *you* were receiving constant medical care.

By "loss" *we* mean complete, permanent, incurable and irreversible loss.

Section 6 – Restrictions

1. When more than one person is insured by this insurance coverage, the benefit cannot exceed the lesser of the amounts stipulated under **Section 4 – Amount of insurance benefits** herein.
2. The benefits in no way cover the *residual value* of the *consumer good*.
3. The benefits in no way cover payments in arrears under the *financing agreement* or any accrued interest thereon.

Section 7 – Exclusions

In addition to exclusions stipulated in the **Section 2 – Exclusions** under the **PART 5 – GENERAL PROVISIONS** herein, no benefit is payable if the *total disability* is the direct or indirect result of:

1. uncomplicated pregnancy or uncomplicated childbirth; or
2. cosmetic or non-medically required surgery; or
3. attempted suicide or intentional self-inflicted *injury*, regardless of *your* state of mind; or
4. chronic or excessive consumption of alcohol or drugs, use of illicit drugs or substances, or misuse of medication obtained with or without a prescription, unless participating in a rehabilitation program that is approved and monitored by a *physician*.

Section 8 – Termination of benefit payments

Benefit payments terminate on the earliest of the following dates:

1. The date on which *we* ask for proof that *you* are still *totally disabled* and if, after 31 days, *we* did not receive the requested documents or are dissatisfied with the documents received;
2. The date on which *we* asked *you* to go for a check-up with the *physician* of *our* choice, but *you* did not go;
3. The date on which *you* are no longer considered *totally disabled*;
4. The date on which *you* carry out gainful occupation;
5. The date on which *you* reached the end of the maximum *benefit period* stipulated in the "Waiting Period and Benefit Period" paragraph in section **F) Insurance Coverages** in *your Insurance Application*. If the maximum period is determined in months, it is cumulated for all *your total disability* leaves, whether benefits were paid consecutively or not;
6. The end date of the coverage stipulated in section **F) Insurance Coverages** in *your Insurance Application*.

Part 3 – Accidental dismemberment insurance coverage

Section 1 – Purpose of coverage

Subject to the other provisions of this certificate, *we* agree to pay an insurance benefit if, while *you* have life insurance coverage, *you* suffer an *accident* that causes losses stipulated in **Section 3 – Conditions for benefit payments.**

Section 2 – Amount of insurance benefits

If *you* opted for life insurance coverage, *you* are automatically covered by this insurance coverage, subject to other provisions herein.

In the event of accidental dismemberment, the benefit is payable to the *creditor* named in the *Insurance Application* upon receipt of medical proof *we* consider satisfactory.

The amount of the benefit is equal to the lesser of the following amounts:

1. **For a loan agreement**, the balance of the contract owed on the date on which *you* suffer the losses as stipulated in the notice issued by the *creditor*;
2. **For a lease agreement**, the present value of future payments remaining upon the date on which *you* suffer the losses and, if *you* opted for this option, the *residual value* of the life insurance coverage indicated in *your Insurance Application*;
3. The initial benefit of the life insurance coverage stipulated in section **F) Insurance Coverages** of *your Insurance Application*;
4. The maximum insurable amount stipulated in section **J) Additional eligibility criteria applicable to the life insurance coverage** in *your Insurance Application*.

Section 3 – Conditions for benefit payments

To be eligible for the insurance benefit, *you* must satisfy the following conditions:

1. as result of *injury*, *you* suffer:
   - **two losses** among the following:
     - loss of use of a hand
     - loss of use of a foot
     - loss of a hand and wrist joint after amputation
     - loss of a foot and ankle joint after amputation

     OR
   - **one loss** among the following:
     - loss of vision in both eyes (a visual acuity of 20/200 or less, or field of vision of less than 20 degrees)
     - loss of speech for a period of at least 6 consecutive months
     - loss of hearing in both ears, with a hearing threshold of more than 90 decibels.
2. these losses occur in the 365 days following the date on which *you* suffer the *accident* and while *your* life insurance coverage was in effect;
3. these losses did not lead to *your* death.

By "loss" *we* mean complete, permanent, incurable and irreversible loss.

Section 4 – Restrictions

1. When more than one person is insured by this insurance coverage, no more than one benefit is payable, to whomever submitted the benefit claims form first.
2. The accidental dismemberment insurance benefit in no way covers payments in arrears under the *financing agreement* or any accrued interest thereon.

Section 5 – Exclusions

In addition to exclusions stipulated in **Section 2 – Exclusions** under **PART 5 – GENERAL PROVISIONS** herein, no benefit is payable if accidental dismemberment results directly or indirectly from:

1. Attempted suicide or intentional self-inflicted *injury*, regardless of *your* state of mind; or
2. *Your* chronic or excessive consumption of alcohol or drugs, use of illicit drugs or substances, or misuse of medication obtained with or without a prescription, unless participating in a rehabilitation program that is approved and monitored by a *physician*.

Part 4 – Temporary insurance agreement during the risk selection process

If *you* must complete a medical questionnaire, in compliance with section **H) Required Medical Questionnaire** in *your Insurance Application*, *you* will be temporarily covered under the life insurance coverage (including accidental dismemberment insurance) if you purchased this coverage and for the period during which *we* analyze *your application* as per the terms and conditions herein and:

1. A maximum coverage amount of $100,000;
2. The temporary insurance terminates on the earliest of the following dates:
    a. the 90th day following the date on which *you* signed the *Insurance Application*;
    b. the date on which *we* accept or deny *your Insurance Application*.

Exclusion: Temporary insurance does not apply if *you* complete the *Insurance Application* after the date on which *you* signed the *financing agreement*.

Part 5 – General provisions
(applicable to all insurance coverages)

Section 1 – Definitions

"Accident" means an unintentional, sudden, unforeseen and unpredictable event:

- that is attributable to a violent external cause; and
- that, directly and independently of any other cause, causes one or more bodily *injuries*.

"Consumer good" means an item that *you* have purchased or leased and for which *you* have signed a *financing agreement*.

"Creditor" means the financing company that grants the loan or lease agreement for *your consumer good*.

"Distributor" refers to the company that sold *you* this insurance.

"Effective date of insurance" means the date on which the insurance takes effect, as stipulated in the *Insurance Application*.

"Family member" means *your* spouse, father, father-in-law, mother, mother-in-law, legal guardian, *your* children and *your* spouse's children, brothers and sisters, half-brothers and half-sisters, grandchildren, grandparents, father's spouse, mother's spouse, sons-in-law, daughters-in-law, uncles and aunts, nephews and nieces.

"Financing agreement" means the loan or lease contract for *your consumer good*.

"Illness" means a deterioration in health or a physical disorder diagnosed by a *physician* and requiring medical treatment.

"Injury" means bodily injury:

- that results directly and solely from an *accident*; and
- that leads to *your total disability*; and
- that is diagnosed by a *physician*.

What is not considered an *injury* is any bodily *injury* resulting from:

- an intentional act; or
- an *illness*; or
- any cause other than an *accident*.

"Insurance Application" means the insurance application *you* signed.

"Physician" means a person other than *yourself* or *family member* or *your* business partner who is licensed to practice medicine in Canada.

"Pre-existing medical condition" means any health problem that includes, but is not limited to, an *illness*, a *critical illness*, an *injury* or any other affliction, like a psychological, nervous or psychiatric disorder, for which, in the 12 months prior to the *effective date of insurance*:

- *you* received a treatment stipulated in the **List of treatments**; or
- *you* had symptoms that would lead a reasonably cautious person to seek a diagnosis, care or treatment.

List of treatments:

i. A diagnosis
ii. A medical opinion
iii. A treatment
iv. A service
v. A prescription drug
vi. A consultation, including a consultation for investigation.

"Residual value" means the predetermined value of the *consumer good* at the end of the lease agreement, as stipulated in this contract.

Section 2 – Exclusions

No benefit is payable if the death, *total disability* or accidental dismemberment results directly or indirectly from:

1. a *pre-existing medical condition* (however, this exclusion is voided if the event that is the subject of the claim occurs more than 18 months after the *effective date of insurance*);
2. participating in a criminal act or attempting to commit a criminal offence;
3. assaults that *you* committed;
4. war, whether declared or undeclared, insurrection, rebellion or *your* participation in a riot or popular uprising;
5. travelling or flying in, or descending from any kind of aircraft, other than as a fare-paying passenger, if the aircraft is only used to transport passengers or passengers and cargo;
6. *your* operating of a motor vehicle, vessel, aircraft or railway equipment if:
   a) *your* blood alcohol level is 80 mg or higher per 100 ml of blood;
   b) the concentration of a drug in *your* blood is equal to or higher than 5 ng of THC per ml of blood;
   c) the concentration of a drug in *your* blood is equal to or higher than 2.5 ng of THC per ml of blood, combined with a blood alcohol level that is equal to or higher than 50 mg or higher per 100 ml of blood;
   d) the presence of any illicit substance in *your* blood;
   e) *you* are taking medication whose prescription includes a warning against driving a motor vehicle.

Section 3 – End of insurance

All the insurance coverages under this certificate will end on the earliest of the following dates:

1. the date on which the *financing agreement* is modified, refinanced, or declared expired by the *creditor* named in *your Insurance Application*;
2. the date on which the *consumer good* is repossessed, sold or is the subject of a court ruling;
3. the date stipulated in *your financing agreement* on which all payments were paid in full, excluding all arrears and interest thereon;
4. for life insurance and accidental dismemberment insurance: the date on which the benefit becomes payable, in compliance with this certificate.

Life, disability and accidental dismemberment insurance coverages will terminate, independently of each other, on the earliest of the following dates:

1. the end date of insurance, for each coverage, as stipulated in *your Insurance Application*;
2. the date on which *we* receive a written notice of termination from *you*;

   If more than one person is insured, *you* can terminate:

   a) *your* insurance only; or
   b) the entire contract. For the latter, the signature of all insured persons is required;
3. the date on which *you* reach the age at which the insurance is set to terminate, as stated below:
   a) For **life and accidental dismemberment coverages**: the date of *your* 73th birthday;
   b) For **disability coverage**: the date of *your* 70th birthday.

   If the insurance covers more than one person, only the portion applicable to the person who reached the age mentioned above ends.
4. the date on which the maximum term, specific for each insurance coverage, is reached, as stipulated in *your Insurance Application*;

Disability insurance ends upon *your* retirement. When more than one person is insured by this insurance coverage, the coverage continues to apply to the person who is not retired.

Section 4 – Rescission right

Upon receipt of a copy of the *Insurance Application*, *you* have **20 days** to cancel this insurance, without penalty.

If that is the case, return this certificate to *us* at the following address by recommended mail or any other method that requires a signature at Reinsurance Management Associates, Inc., 170 University Ave, Suite 500, Toronto, Ontario, M5H 3B3.

Upon receipt, *we* will cancel *your* insurance retroactively to the *effective date of insurance* and reimburse the premium paid.

Section 5 – Premium reimbursement

If *your* insurance is terminated or cancelled during the term, *we* will reimburse the premium as follows:

1. The entirety of *your* premium is reimbursed if:
   a) *your Insurance Application* is denied; or
   b) *you* are considered not eligible on the *effective date of insurance*; or
   c) *your* insurance is cancelled in the 20 days following receipt of a copy of the *Insurance Application*.
2. In all other cases, *your* reimbursement is calculated using one of the two calculation methods below, pending receipt of *your* notice of termination:

Method 1: The reimbursement is calculated according to **Rule of 78**, reduced by:

- all benefits paid under this insurance certificate; and
- a $125 termination fee (this fee is applied only once per application).

Rule of 78 is a standard mathematical formula used in the industry to calculate the unused portion of a premium. It is defined as follows:

$$(\text{Premium} - \text{Policy fee}) \times ((A - B) \times (A - B + 1)) / (A \times (A + 1))$$

where:
A = Term of insurance (in months)
B = Number of months during which the insurance was in effect
Policy fee = $100

OR

Method 2: The reimbursement is calculated prorated to the number of months during which the insurance was in effect. The reimbursement of the premium will not be reduced by any benefit paid or any termination fee. Moreover, the policy fee will not be deducted from the premium when calculating the premium reimbursement.

Method 2 applies to the following *creditors*: Ford Credit Canada, Lincoln Automotive Financial Services, Volkswagen Credit Canada, Toyota Credit Canada, Financial Services Nissan Canada and Honda Canada Finance. To find out *your* reimbursement amount, please call *us* at 1-888-307-7443.

If *you* send *us* proof that all *your financing agreement* payments have been made, the premium reimbursement will be made directly to *you*. In all other cases, the reimbursement of premiums is made to the *creditor* to reimburse *your financing agreement*, whether in whole or in part.

Restriction: In all cases, the reimbursement amount must be at least $5 to be reimbursed.

A cancellation retroactively ends a policy, as though it never existed.

A termination (end of insurance) ends a policy on a given date (after it has taken effect). The policy is no longer in effect, but it doesn't erase the past.

Section 6 – Benefit claims

For the purposes of this section, the words *you*, *your* or *yours* can also refer to *your* estate in the event of *your* death.

You must call 1-888-307-7443 (toll free) to obtain a benefit claims form.

In addition to the benefit claims form, please provide all corroborating documents.

To make it easier to process *your* claim, please provide the following documents to *us* by their respective deadlines:

1. For life and accidental dismemberment insurance, by **no later than one year** after the date of death or loss;
2. For disability insurance, by **no later than 90 days** after the start of *total disability*.

If proof is required to process a benefit claim and it is not provided to *us*, the claim could be denied.

We will examine the benefit claim upon receipt and send a response within 30 days, provided all the necessary documents have been received.

If *we* consider the benefits to be payable based on the information provided, *we* will issue a cheque payable to the *creditor* in the 30 days following receipt of the benefit claim and send *you* a confirmation of benefit payment.

If the benefit claim is denied, *you* (or *your creditor*) can request a review of *your* file. To do so, *you* must:

1. explain why *you* want the claim to be reviewed; and
2. append all additional corroborating documents to *your* request for review.

If *you* are still unsatisfied with the decision rendered after review, *you* may also submit an official complaint to *our* Complaint Handling Department. To find out how, please call 1-888-307-7443.

A summary of *our* complaint handling policy is available here: https://securiancanada.ca/complaints.

You can also contact the Autorité des marchés financiers (AMF).

Section 7 – False declarations on important facts, *your* health or *your* medical information

The information *you* provide *us* must always be factual and complete.

This insurance certificate is based on the information provided in *your Insurance Application* or related to the latter (including the answers to the medical questionnaire, if any). When *you* complete the *Insurance Application* and answer the medical questionnaire, *your* answers must be factual and complete. In the case of a benefit claim, *we* audit this information. If one of *your* answers is not factual or incomplete:

1. *your* coverage could be cancelled;
2. *your* benefit claim could be denied.

Section 8 – Notice of constitution of a file and personal information use

Notice of constitution of a file

Respecting *your* privacy is a priority for Canadian Premier Life Insurance Company. *We* collect information from application forms and other information *you* provide to *us* or *our* distribution partners in connection with insurance and/or financial products offered by *us*.

Collection and use of *your* personal information

We collect, use and disclose *your* personal information for purposes that include: confirming *your* identity, underwriting, including determining *your* eligibility or need for insurance and/or financial products *you* request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. *We*, and *our* affiliates, may use the personal information for the purpose of offering *you*, or allowing select organizations to offer *you*, other products and services.

You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. *We* will give access to *your* personal information only to those of *our* employees and independent contractors, affiliates within *our* corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with *our* reinsurers, who need *your* personal information to do their jobs. *We* will also provide access to anyone else *you* authorize.

All of *our* service providers with whom *we* have a contractual relationship are required to protect *your* personal information in accordance with this privacy statement and *our* privacy practices. Sometimes, unless *we* are otherwise prohibited, these people may be in, or *your* personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so *your* personal information may be subject to the laws of those other provinces or countries. *You* can ask for the information in our files about *you* and, if necessary, ask *us* in writing to correct it.

Personal Information Protection Officer

Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6.

To find out more about *our* privacy practices, visit: http://www.securiancanada.ca/privacy-statement.

Notice of rescission of an insurance contract

NOTICE GIVEN BY A DISTRIBUTOR

Section 440 of the Act respecting the distribution of financial products and services (chapter D-9.2)

THE ACT RESPECTING THE DISTRIBUTION OF FINANCIAL PRODUCTS AND SERVICES GIVES YOU IMPORTANT RIGHTS.

The Act allows you to rescind an insurance contract, **without penalty**, within 10 days of the date on which it is signed. However, the insurer may grant you a longer period.

To rescind the contract, you must give the insurer notice, within that time, by registered mail or any other means that allows you to obtain an acknowledgement of receipt.

Despite the rescission of the insurance contract, the first contract entered into will remain in force. Caution, it is possible that you may lose advantageous conditions as a result of this insurance contract; contact your distributor or consult your contract.

After the expiry of the applicable time, you may rescind the insurance contract at any time; however, penalties may apply.

For further information, contact the Autorité des marchés financiers at 1-877-525-0337 or visit www.lautorite.qc.ca.

NOTICE OF RESCISSION OF AN INSURANCE CONTRACT

To: Reinsurance Management Associates, Inc.
170 University Ave, Suite 500, Toronto, Ontario, M5H 3B3

Date: _____ *(date of sending of notice)*

Pursuant to section 441 of the Act respecting the distribution of financial products and services,
I hereby rescind insurance contract no.: _____ *(number of contract, if indicated)*

Entered into on: _____ *(date of signature of contract)*

in: _____ *(place of signature of contract)*

_____ *(name of client)*

_____ *(signature of client)*

CPL 2023-07, Ann. 1.