

# INSURANCE APPLICATION



Young Bar Association of Montreal

Policy 17142 - Period from August 1<sup>st</sup>, 2009 to July 31<sup>th</sup>, 2010

INFORMATION ABOUT YOU		
Name (first and last name)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (day/month/year)
Former name	<input type="checkbox"/> English <input type="checkbox"/> French	Place of birth (province/country)
E-mail	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker Non-smoker means that you have not used any tobacco products or tobacco cessation products within the last 12 consecutive months	
Address (residence or office)		
City	Province	Postal code
Telephone (homee)	Telephone (office)	Fax

INFORMATION ABOUT YOUR SPOUSE (Required only if you apply for couple or family coverage)		
Name (first and last name)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (day/month/year)
Common law spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation: _____	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker Non-smoker means that you have not used any tobacco products or tobacco cessation products within the last 12 consecutive months.
Date of cohabitation: _____ (day/month/year)		

INFORMATION ABOUT YOUR CHILDREN (Required only if you apply for Single parent or Family coverage)			
Name of the child (first and last name)	Date of birth (day/month/year)	Sex	Student
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No

LIFE INSURANCE AND ADD (Included with every option)	
Amount of insurance offer: \$50,000 (options 1, 2 and 3) \$25,000 (options 4, 5 and 6)	Beneficiary designation* <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Beneficiary (name in full)	Relationship to proposed insured

\*You must check revocable or irrevocable for this application to be considered complete. Where Quebec law applies, a spouse is irrevocable unless you make the designation revocable. If the beneficiary designation is revocable, the applicant can change the beneficiary at any time without the beneficiary's consent. If the beneficiary designation is irrevocable, the beneficiary's written consent is required in order for the applicant to make any change in the beneficiary or the coverage.

LIFE INSURANCE AND ADD FOR THE DEPENDANTS (If you choose a Couple, Single parent or Family coverage for Drugs insurance, these benefits are included)	
<b>Spouse</b> \$5,000	<b>Child (after 24 hours)</b> \$2,500 The applicant is automatically the beneficiary for the spousal and dependent child life coverage.

PREMIUM PAYMENT METHOD
<p><b>Check one box only:</b></p> <p><input type="checkbox"/> <b>Monthly Pre-authorized payment:</b> monthly administration fee of \$1 will be applied to the monthly premium. In order to choose this type of payment, please fill in the section "Pre-authorized payment"</p> <p><input type="checkbox"/> <b>Payment by credit card:</b> administration fee of \$1 per transaction will be applied. In order to choose this type of payment, please fill in the section "Credit Card Payment Authorization" <input type="checkbox"/> Annual <input type="checkbox"/> Bimonthly <input type="checkbox"/> Quarterly</p> <p><input type="checkbox"/> <b>Annual payment by check:</b> Please calculate your premium in prorata according to the annual renewal date of members. The annual renewal date is August 1<sup>st</sup> each year to July 31<sup>th</sup> of the next year. The check must be payable to MédicAssurance Inc..</p>

### PRE-AUTHORIZED PAYMENT

I authorize, MédicAssurance inc., to withdrawal funds from my (our) account for the purposes of paying the monthly premium and to adjust the withdrawal if my monthly premium changes (following a written notice of 30 days before the effective date of the change).

NAME OF THE BANK: \_\_\_\_\_

ADDRESS OF THE BANK: \_\_\_\_\_

SIGNATURE OF ACCOUNT HOLDER: \_\_\_\_\_

SIGNATURE OF ACCOUNT HOLDER: \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE ATTACH A VOID CHECK**  
(a copy is accepted)

### CREDIT CARD PAYMENT AUTHORIZATION

I authorize, MédicAssurance inc.; to charge my credit card for the amount due according to my insurance certificate; to adjust the amount charged to my credit card should the premiums change if a 30 days notice in writing has been given prior to the adjustment. This authorization can be cancelled at any time with 30 day's written notice.

Visa     Master Card     Amex

CARD NUMBER: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

NAME AS INDICATED ON THE CREDIT CARD: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### DECLARATION AND AUTHORIZATION

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application will cause the insurance to be void. A photocopy version of this declaration is as valid as the original, and shall remain in effect for the duration of my insurance coverage.

Signature of the applicant

Date of the signature (day/month/year)

To ensure the confidentiality of the personal information held on you, MédicAssurance inc. will set up an insurance file in which be entered the information provided on your insurance application, as well as any claim information.

Only those employees or representatives responsible for underwriting, investigating and processing claims or any other person authorized by yourself will have access to this file. Your file will be kept in our offices. You are entitled to consult the personal information contained in this file and to have it rectified, if necessary, by sending a written request to one of the following addresses:

- 1255, University Street, Suite 217, Montreal (Quebec) H3B 3B2
- 5300, boulevard des Galeries, Suite 310, Quebec (Quebec) G2K 2A2

**IMPORTANT:**

Your insurance coverage will be effective on the 1<sup>st</sup> of the following month upon receipt of your application duly completed unless you specify otherwise hereunder. The coverage cannot be effective other than the 1<sup>st</sup> of the month.

I wish my coverage be effective on the 1<sup>st</sup> of the month of \_\_\_\_\_. Your initials \_\_\_\_\_

## Direct card

Monthly premium 9% tax included

### OPTION I ■

(Life insurance - \$50,000, ADD, Drugs with deductible \$150 / \$250 - reimbursement: 75%, if generic drugs - reimbursement: 100%)

AGE	WOMEN				MEN			
	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>
18 - 24	\$64,18	\$92,20	\$73,47	\$95,19	\$55,34	\$94,84	\$76,12	\$97,84
25 - 29	\$65,35	\$94,53	\$75,97	\$98,51	\$56,29	\$97,18	\$78,62	\$101,15
30 - 34	\$66,80	\$97,38	\$78,95	\$102,53	\$57,44	\$100,03	\$81,60	\$105,18
35 - 39	\$69,16	\$102,14	\$83,96	\$126,65	\$59,33	\$104,77	\$86,60	\$111,80
40 - 44	\$84,94	\$125,09	\$103,29	\$154,49	\$74,31	\$129,42	\$107,60	\$137,85
45 - 49	\$105,94	\$153,59	\$127,41	\$188,90	\$95,04	\$160,66	\$134,48	\$170,78
50 - 64	\$161,99	\$225,40	\$190,06	\$273,06	\$162,75	\$250,44	\$215,10	\$264,09

### OPTION 2 ■

(Life insurance - \$50,000, ADD, Drugs - reimbursement: 75%, if generic drugs - reimbursement: 100%, Extended Health Care - reimbursement: 80%, deductible \$150 / \$250 applicable to all medical expenses excluding hospital expenses and expenses incurred outside the province or the country, Travel Insurance and Trip Cancellation Insurance)

AGE	WOMEN				MEN			
	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>
18 - 24	\$90,25	\$142,88	\$107,75	\$147,72	\$76,20	\$145,54	\$121,31	\$158,06
25 - 29	\$103,87	\$160,71	\$129,59	\$170,04	\$87,08	\$163,36	\$132,23	\$172,68
30 - 34	\$105,65	\$167,20	\$136,61	\$179,37	\$88,53	\$169,82	\$139,28	\$182,09
35 - 39	\$110,29	\$178,27	\$146,35	\$192,67	\$92,23	\$180,92	\$158,41	\$207,58
40 - 44	\$134,28	\$216,44	\$178,15	\$233,75	\$113,75	\$220,79	\$193,78	\$252,78
45 - 49	\$165,13	\$263,24	\$217,27	\$283,98	\$142,38	\$270,28	\$237,91	\$308,67
50 - 64	\$241,90	\$373,40	\$311,36	\$401,42	\$226,69	\$398,45	\$354,70	\$450,28

### OPTION 3 ■

(Life insurance - \$50,000, ADD, Drugs - reimbursement: 75%, if generic drugs - reimbursement: 100%, Extended Health Care - reimbursement: 80%, deductible \$150 / \$250 applicable to all medical expenses excluding hospital expenses and expenses incurred outside the province or the country, Travel Insurance and Trip Cancellation Insurance, Dental - reimbursement: 80%)

AGE	WOMEN				MEN			
	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>
18 - 24	\$164,36	\$291,11	\$244,10	\$329,51	\$150,31	\$293,77	\$257,66	\$339,85
25 - 29	\$177,98	\$308,94	\$265,94	\$351,83	\$161,19	\$311,59	\$268,58	\$354,47
30 - 34	\$179,76	\$315,43	\$272,96	\$361,16	\$162,64	\$318,05	\$275,63	\$363,88
35 - 39	\$184,40	\$326,50	\$282,70	\$374,46	\$166,34	\$329,15	\$294,76	\$389,37
40 - 44	\$208,39	\$364,67	\$314,50	\$415,54	\$187,86	\$369,02	\$330,13	\$434,57
45 - 49	\$239,24	\$411,47	\$353,62	\$465,77	\$216,49	\$418,51	\$374,26	\$490,46
50 - 64	\$316,01	\$521,63	\$447,71	\$583,21	\$300,80	\$546,68	\$491,05	\$632,07

### OPTION 4 ■

(Life insurance - \$25,000, ADD, Drugs with deductible \$800 / \$800 - reimbursement: 100%)

AGE	WOMEN				MEN			
	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>
18 - 24	\$28,71	\$41,98	\$33,73	\$43,31	\$24,97	\$43,31	\$35,06	\$44,63
25 - 29	\$29,23	\$43,02	\$34,83	\$44,79	\$25,39	\$44,34	\$36,16	\$46,12
30 - 34	\$29,86	\$44,27	\$36,15	\$46,54	\$25,88	\$45,61	\$37,47	\$47,88
35 - 39	\$30,90	\$46,37	\$38,35	\$57,20	\$26,71	\$47,70	\$39,68	\$50,79
40 - 44	\$38,05	\$57,22	\$47,57	\$70,19	\$33,62	\$59,37	\$49,74	\$63,09
45 - 49	\$47,68	\$70,14	\$58,61	\$85,73	\$43,27	\$73,67	\$62,10	\$78,12
50 - 64	\$73,82	\$103,26	\$87,68	\$124,29	\$75,62	\$115,78	\$100,18	\$121,80

### OPTION 5 ■

(Life insurance - \$25,000, ADD, Drugs - reimbursement: 100%, Extended Health Care - reimbursement: 80%, deductible \$800 / \$800 applicable to all medical expenses excluding hospital expenses and expenses incurred outside the province or the country, Travel Insurance and Trip Cancellation Insurance)

AGE	WOMEN				MEN			
	Single □	Couple □	Single parent □	Family □	Single □	Couple □	Single parent □	Family □
18 - 24	\$40,22	\$64,36	\$48,85	\$66,49	\$34,18	\$65,68	\$55,00	\$71,23
25 - 29	\$46,19	\$72,21	\$58,50	\$76,32	\$38,96	\$73,55	\$59,83	\$77,67
30 - 34	\$46,99	\$75,09	\$61,59	\$80,45	\$39,59	\$76,42	\$62,93	\$81,81
35 - 39	\$49,05	\$79,96	\$65,88	\$86,30	\$41,24	\$81,30	\$71,36	\$93,06
40 - 44	\$59,83	\$97,51	\$80,63	\$105,13	\$51,03	\$99,69	\$87,78	\$113,83
45 - 49	\$73,81	\$118,49	\$98,24	\$127,64	\$64,18	\$122,03	\$107,74	\$138,99
50 - 64	\$109,10	\$168,54	\$141,19	\$180,88	\$103,85	\$181,08	\$161,77	\$203,96

### OPTION 6

(Life insurance - \$25,000, ADD, Drugs - reimbursement: 100%, Extended Health Care - reimbursement: 80%, deductible \$800 / \$800 applicable to all medical expenses excluding hospital expenses and expenses incurred outside the province or the country, Travel Insurance and Trip Cancellation Insurance, Dental - reimbursement: 80%)

AGE	WOMEN				MEN			
	Single □	Couple □	Single parent □	Family □	Single □	Couple □	Single parent □	Family □
18 - 24	\$114,33	\$212,59	\$185,20	\$248,28	\$108,29	\$213,91	\$191,35	\$253,02
25 - 29	\$120,30	\$220,44	\$194,85	\$258,11	\$113,07	\$221,78	\$196,18	\$259,46
30 - 34	\$121,10	\$223,32	\$197,94	\$262,24	\$113,70	\$224,65	\$199,28	\$263,60
35 - 39	\$123,16	\$228,19	\$202,23	\$268,09	\$115,35	\$229,53	\$207,71	\$274,85
40 - 44	\$133,94	\$245,74	\$216,98	\$286,92	\$125,14	\$247,92	\$224,13	\$295,62
45 - 49	\$147,92	\$266,72	\$234,59	\$309,43	\$138,29	\$270,26	\$244,09	\$320,78
50 - 64	\$183,21	\$316,77	\$277,54	\$362,67	\$177,96	\$329,31	\$298,12	\$385,75

### LONG TERM DISABILITY INSURANCE (PER \$100) ■

Join the proof of health application completed with copy of your last Federal Income Tax Report for this option (119 days waiting period)

AGE	WOMEN	MEN
18 - 24	\$0,41	\$0,37
25 - 29	\$0,55	\$0,45
30 - 34	\$0,72	\$0,59
35 - 39	\$1,20	\$0,96
40 - 64	\$5,82	\$4,32



# Declaration of insurability (Group insurance)



ASSOCIATION DU JEUNE BARREAU DE MONTRÉAL  
YOUNG BAR ASSOCIATION OF MONTREAL

Employer's name		Policy number
Adherent's name (or dependent's name)		Certificate number
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth	Social insurance number _ _ _ _ _ _ _ _ _ _

Are you currently employed?    Yes     No     If yes, number of hours per week \_\_\_\_\_  
If no, indicate the reason \_\_\_\_\_

**Answer each of the following questions and, if the answer is YES, please explain.**

<p><b>Currently:</b>    Height: _____    Weight: _____</p> <p>1. Do you carry on all usual duties related to your job?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>2. Do you have a physical limitation because of which you need to use a device? .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>3. Are you planning to consult a doctor for a symptom or a disease or for treatment or surgery in the future?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>4. Are you taking medications or receiving a treatment prescribed by a doctor?.....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p><b>During the last five years:</b></p> <p>5. Have you been hospitalized for surgery or treatment?.....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>6. Have you received insurance or government benefits for a disability? .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>7. Has your driving permit been suspended? When? Why?.....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>8. Have you been treated or has it been recommended that you be treated for alcohol or drug abuse? .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>9. Have you used drugs or narcotics without a doctor's order? .....    Yes <input type="checkbox"/>    No <input type="checkbox"/> Indicate which drug(s) or narcotic(s) and the date(s) of use</p>	<p><b>During your lifetime:</b></p> <p>10. Have you experienced one or several of the following conditions:</p> <p>a) Cardiac or blood vessel disorders, including stroke, heart attack, angina .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>b) Chronic breathing trouble, including bronchitis, emphysema, asthma .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>c) Digestive problems, including Crohn's disease, colitis, hepatitis .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>d) Genitalia, prostate or kidney disorders .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>e) Endocrine disorders, including diabetes .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>f) Bone or joint disorders, including back pain .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>g) Neurological disorders, including epilepsy, palsy, chronic fatigue, depression .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>h) Cancer or tumor, blood disease, HIV positive test .....    Yes <input type="checkbox"/>    No <input type="checkbox"/></p>
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**Explain each "yes" answer to above questions. Use additional sheet of paper, if necessary.**

Question N°	Diseases, events, substances, treatments, medications	Date	Names and addresses of health or hospital professionals

<b>Declaration</b>	I declare that the above answers are accurate and complete and I accept that they are an integral part of my application for insurance. I acknowledge having thorough knowledge of the notice on the back page and having received copy of such. The insurance will become effective on the date of acceptance by La Survivance, compagnie mutuelle d'assurance vie, of the insurability report. Any false declaration may result in the cancellation of the insurance.
_____	_____
Adherent's signature	Witness' signature
	_____
	Date

<b>Authorization</b>	I authorize any doctor, hospital, clinic, insurance or investigation company, the Medical Information Bureau or other organizations or institutions having information about me or a member of my family to provide this information to La Survivance, compagnie mutuelle d'assurance vie or to reinsurers. A photocopy of this authorization has the same value as the original
_____	_____
Adherent's signature	Witness' signature
	_____
	Date

## **Notice**

### **Medical Information Bureau**

The information La Survivance may obtain from different sources regarding your insurability will be treated confidentially.

La Survivance may, however, make a brief report there on to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon your request the Bureau will transmit to you any information in your file except medical information which will be disclosed only to your attending physician. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's information office is:

Medical Information Bureau  
330, University Avenue, Suite 403  
Toronto (Ontario) M5G 1R7  
Telephone: (416) 597-0590

La Survivance may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

### **Investigation report**

In the process of the study of your proposition, we inform you that an investigation report might be requested in order to gather informations coming from personal interviews with your acquaintances. The investigation may revolved around your reputation, your lifestyle and your finances.

It is possible that a representative from a society that is doing such reports, visits or phones you.