Polzin Insurance and Consultants

CERTAINTY-LIFE APPLICATION

PROPOSED INSURED

1. Name: _____ (first / middle / last)

_____ (name at birth) Sex: ☐ M ☐ F

S.I.N. _____

2. Address: _____ (street / city / province / postal code)

3. Date of birth: _____ (month) _____ (day) _____ (year) Age: _____ (use current age) Tel.: ( ) _____

OWNER *(if other than the proposed insured)*

4. Name: _____ (first / middle / last)

Address: _____ (street / city / province / postal code)

Tel.: _____

S.I.N. _____ Age: _____ Relationship: _____

BENEFICIARY

5. Name: _____ (first / middle / last)

Age: _____ Relationship: _____ ☐ Revocable ☐ Irrevocable

POLICY INFORMATION

6. Face amount of insurance: $ Annual premium _____ $

Payment: ☐ Annual ☐ M.A.P. (pre-authorized Monthly Automatic Payment)

Sum received $ (an initial payment equal to the monthly premium must be paid)

7. Will this insurance replace any existing insurance with any company or society?

☐ No ☐ Yes *If yes, please complete and attach a comparison disclosure statement*

ACA ASSURANCE
3050, boul. St-Jean, Trois-Rivières-Ouest, (Québec) G9A 5E1
www.aca-assurance.com

STATEMENT

8. I hereby declare that I am not now confined in a hospital, clinic or nursing, rest or convalescent home. To the best of my knowledge, I do not have AIDS, AIDS Related Complex (ARC) and during the last 2 (two) years, I have not been diagnosed or treated for any form of cancer.

I agree to abide by all provisions of the Society's Constitution and By-laws. I agree that the insurance applied for shall go into effect on the date the application is approved at the Society's home office and the first premium is paid.

Signed at _____ this _____ day of _____ 20 2005

_____ signature of owner (if necessary)

_____ signature of proposed insured

_____ signature of witness or agent

AGENT'S STATEMENT

9. I saw the client ☐ I have not seen the client ☐ If not, give the reason why;

Based on the informations given to me, the Proposed Insured is not presently confined to a bed, or in a hospital, clinic or nursing, rest or convalescent home. Also, I have not been informed of, nor am I aware of the Proposed Insured having AIDS, AIDS Related Complex (ARC) and during the last 2 (two) years, have not been diagnosed or treated for any form of cancer. As far as I know, this insurance applied for ☐ will ☐ will not replace a life insurance policy now in force on the life of the Proposed Insured.

Print name of agent _____ Agent no. _____ Date _____ Agent's signature _____

MONTHLY AUTOMATIC PAYMENT AUTHORIZATION (MAP)

DAY OF WITHDRAWAL _____

a) Complete this authorization form, to authorize ACA ASSURANCE to charge your checking account for the monthly premium due.
b) Send a void check, unsigned, of your financial institution

Payor: _____ name on your account

Bank: _____ full name of financial institution

I hereby authorize ACA ASSURANCE to initiate debit entries to my checking account and the financial institution named above is directed to debit the same to such account. This authorization will remain in effect until revoked by me in writing. My signature below is exactly as I sign my personal checks.

_____ payor's signature

_____ date

HOME OFFICE USE ONLY

Chapter no. ☐ ☐ Approved ☐ Refused Date _____

780E 11/2003 - 5M

RECEIPT

Received from _____ the sum of _____

for the insurance on the life of _____

_____ date

_____ agent's signature