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FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Enrolment Form
General Officers' Insurance Plan (GOIP), Reserve GOIP and Military Post Retirement Life Insurance Plan (MPRLIP)

Manulife

1. MEMBER'S INFORMATION

Service Number (SN)	Rank	Surname	First Name	Initials

Apt.	Civic #	Street	Date of Birth (dd-mm-yyyy)

PO Box, Rural Route, etc.	City	Province	Postal Code

Primary/Day Telephone	Secondary/ Evening Telephone	E-mail Address

Check one Box Only:

☐ GOIP
☐ RES-GOIP

Date of Promotion: dd | mm | yyyy

☐ MPRLIP

Date of Release: dd | mm | yyyy

Pension Number

2. CLASS OF SERVICE (FOR GOIP & RES-GOIP ONLY)

☐ Regular Force * ☐ Primary Reserve Class "C" * ☐ Primary Reserve Class "B" of more than 180 days * ☐ Primary Reserve Class "A" ☐ Primary Reserve Class "B" of 180 days or less

*For Officers in Regular Force; Primary Reserve on Class "C" service; or, Primary Reserve on Class "B" service of more than 180 days.

Optional coverage: ☐ 1 time salary ☐ Not requested

3. MEMBER'S COVERAGE – BENEFICIARY DESIGNATION Applies to both Basic and Optional coverage(s)

Note 1: The previous designation of a spouse by a member who became insured under SISIP Financial while residing in the province of Quebec may be irrevocable for the duration of the coverage, and if the case a change cannot be made without the spouse's written permission. If applicable, the irrevocable beneficiary must complete and sign the Release of Beneficiary form (Annex to 11E) and attach it to this application.

Note 2: The member (Block 1) may name any person(s) and/or organization(s) to be their beneficiary. If more than one primary beneficiary is to be named, tick PRIMARY in each applicable row and enter the desired percentage for each beneficiary in the last column. The total must equal 100%. If insufficient space, please complete the Designation/Change of Beneficiary form (11E) and attach it to this application. If minor children are included, the date of birth of the children and the name and address of the Trustee/Tutor must be completed. Tick CONTINGENT for the naming of a secondary beneficiary in the case of death of the primary beneficiary(ies). The total for all contingent beneficiary(ies) must also equal 100%.

As the certificate holder, I hereby revoke any previous beneficiary designation(s) which I may have made under the Group Policy No. 901102 and hereby designate the following beneficiary(ies). This beneficiary designation is revocable unless stated otherwise.

Beneficiary(ies):	Name (in full) of Persons or Organizations	Relationship	Date of Birth dd	mm	yyyy	Percentage
☐ PRIMARY						%
☐ PRIMARY ☐ CONTINGENT						%
☐ PRIMARY ☐ CONTINGENT						%

TRUSTEE/TUTOR | Address and telephone #:

4. SIGNATURE

Note 1: *MIB - to review information on your file, or have it corrected, visit www.mib.com for contact information.

Declaration and Authorization by Applicant

The responses and declarations contained herein are true and complete. I realize that any material misrepresentation will render void the insurance. I hereby apply for the insurance to which I am entitled or to which I may become entitled under the provisions of the General Officers' Insurance Plan (GOIP); the Reserve GOIP; or the Military Post Retirement Life Insurance Plan (MPRLIP). I understand that it will be necessary for military authorities to exchange personal information for verification of eligibility and for statistical purposes. In addition:

a. to gather only that information necessary for the object of the file, from any person or organization that has personal information relating to me, including other insurers, physicians and medical institutions, the Medical Information Bureau (MIB*), investigation and credit reporting agencies, and all persons or organizations likely to have personal information relevant to the object of the file;
b. to disclose only the necessary personal information it has relating to me to these same persons and organizations, specified in paragraph (a); or,
c. to request a personal investigation report relating to me.

A copy of this authorization shall be as valid as the original. This authorization is valid for the period required to achieve the ends for which it was requested.

I understand that the new coverage(s) applied for is subject to the approval of SISIP Financial and/or Manulife. Therefore, I understand that NO action should be taken to terminate existing insurance coverage(s) until notified of the decision regarding this application.

The information provided on this form is protected from unauthorized disclosure under Canada's *Privacy Act*, *Personal Information Protection and Electronic Documents Act* (PIPEDA) or equivalent provincial legislation and is available to you upon request.

CAF Member's Name Printed:

CAF Member's Signature: dd | mm | yyyy

I consent to being notified or contacted regarding other SISIP Financial products or services:

Initial: _____ YES or _____ NO

Submit completed document to: SISIP Financial, National Defence Headquarters, 4210 Labelle Street, Ottawa, ON K1A 0K2

SISIP FINANCIAL OFFICE USE ONLY

GOIP or Res-GOIP Effective: dd | mm | yyyy

Monthly Cost : $ *(GOIP Optional Only)*

MPRLIP Effective: dd | mm | yyyy