A division of CFMWS
Une division des SBMFC

Reserve Force
Optional Long Term Disability (LTD) Coverage

(only available to Primary Reservists on Class "A" service, or, Class "B" service of 180 days or less)

Mail to:
SISIP Life Insurance – Manulife
P.O. Box 1030, 2727 Joseph Howe Dr.
Halifax, NS B3J 2X5
1-800-565-0701 | SISIP.com

1. PURPOSE OF THIS APPLICATION (CHECK ALL THAT APPLY):

☐ **Initiate:** Optional LTD coverage ☐ **Increase:** Optional LTD coverage ☐ **Decrease:** Optional LTD coverage

2. MEMBER INFORMATION

Service Number (SN)	*CFOne #*	*Rank*

Date of Birth (dd-mm-yyyy)	*Surname*	*First Name*	*Initials*	*M* ☐ *F* ☐

Date of Enrollment (DOE) (dd-mm-yyyy)	*Primary/Day Telephone*	*Secondary/ Evening Telephone*

Apt.	*Civic #*	*Street*	*City*

Province	*Postal Code*	*Email Address*

3. MEMBER OPTIONAL LONG TERM DISABILITY (LTD) COVERAGE

Note 1: Members of the Primary Reserve on Class "A" service or Primary Reserve on Class "B" service of 180 days or less, unless enrolling under one of the Optional Coverages, automatically acquire at no cost the Basic Coverage for a deemed salary of $2,700, when authorized for service and entitled to pay.
Note 2: Members of the Primary Reserve on Class "B" service of **more** than 180 days acquire the coverage based on their rate of pay, also at no cost.

1. To obtain optional coverage the response **MUST** be **YES** to both questions.
   A. Are you a member of the Primary Reserve? **YES** ☐ **NO** ☐
   B. Are you a member of the Primary Reserve on Class "A" service or Primary Reserve on Class "B" service of 180 days or less? **YES** ☐ **NO** ☐
   ☐ Optional Salary $3,700/month . . . . Cost: $35.59
   ☐ Optional Salary $4,700/month . . . . Cost: $71.18
   Total Monthly Premium ____________
2. The member must attach a copy of the "Route Letter" or the "Employment Message" and a letter from their civilian employer indicating the applicant's annual salary, or, if self-employed, a letter from an at arm's length professional attesting to the applicant's annual income. Total annual salary or income must equal or exceed chosen deemed salary or income.

4. PREMIUM REQUIRED

1. If **ONLY** applying for Optional LTD Coverage in Block 3, the application must be accompanied by a cheque or money order for the **Total Annual Premium** payable to "Manulife" per Block 5. You will be invoiced annually thereafter.
2. If applying for Optional LTD Coverage (this form) AND life insurance coverage (by completing the Reserve Force Reserve Term Insurance Plan (RTIP) form (21E)), the applicant has the option of paying the **Total Monthly Premium** per Block 5 using the "pre-authorized Debit agreement (PAD)" by completing Block 11 on form 21E; or, by submitting a cheque or money order payable to "Manulife" for the **Total Annual Premium** per Block 5; or, if you wish the **Total Monthly Premium** can be deducted from your CAF Pension by completing the CFSA Pension Deduction Authorization form (ML03E).

5. SUMMARY OF PREMIUM REQUIRED (SEE BLOCK 3)

I elect to pay premiums:

a. ☐ monthly through the "pre-authorized debit agreement" by completing Block 11 of 21E; or,
b. ☐ monthly by completing the CFSA Pension Deduction Authorization form (ML03E); or,
c. ☐ annually by cheque or money order for the **Total Annual Premium** in this Block 5, payable to Manulife 60 days after my release date. I will be invoiced annually thereafter.

Optional LTD Coverage, Block 3B =
Total Monthly Premium ____________
Total Monthly Premium × 12 Months = **Total Annual Premium** ____________

SN:

6. SIGNATURE (to be read and signed for all submissions)

Note 1: *MIB - to review information on your file, or have it corrected, visit www.mib.com for contact information.
Note 2: For further details regarding the completion of this form or concerning the Reserve Force LTD Plan or the Reserve Term Insurance Plan please contact SISIP Life Insurance – Manulife at 1-800-565-0701 (in Halifax at 902-453-4300), or SISIP Financial at 1-800-267-6681.
Note 3: Forward your completed application form to: SISIP Life Insurance – Manulife, P.O. Box 1030, 2727 Joseph Howe Drive, Halifax, Nova Scotia B3J 2X5.

The responses and declarations contained herein are true and complete. I realize that any material misrepresentation will render void the insurance. I hereby authorize SISIP Financial and Manulife or its reinsurers, for underwriting and administration of insurance and claims paying purposes only:

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

Spouse's Name Printed: ____________ **Spouse's Signature:** ____________ *dd* *mm* *yyyy*

Spouse's signature is only required to initiate or increase their coverage.

I consent to being notified or contacted regarding other SISIP Financial products or services: Initial: __________ YES or __________ NO

7. SISIP FINANCIAL ADVISOR who assisted in the completion of and/or reviewed this form

Once this area is completed, this form is to be sent immediately to SISIP Financial.

Name	*Branch*		
Signature	*dd*	*mm*	*yyyy*

Was an Insurance Needs Analysis (INA) completed (initial): ______________

YES ☐ **NO** ☐

8. APPROVING AUTHORITY (to be completed by Manulife)

The Member insurance coverage is:	Cancelled ☐	Postponed ________ year(s) ☐	Denied ☐	☐ Approved, effective date	*dd* *mm* *yyyy*
The Spousal insurance coverage is:	Cancelled ☐	Postponed ________ year(s) ☐	Denied ☐	☐ Approved, effective date	*dd* *mm* *yyyy*
The current coverage in force is:	Res LTD ☐	Res LTD (optional) ☐	RTIP (M) ____	RTIP (S) ____	Res GOIP (Basic) ☐ Res GOIP (Optional) ☐

dd *mm* *yyyy* | *Manulife*