FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Coverage After Release (CAR)
Election Form
Group Policy # 901102

Manulife

Reset Print

1. MEMBER INFORMATION

Service Number (SN) | Rank | Surname | First Name | Initials

Mailing Address | Home Phone # ( )

PO Box, Rural Route, etc. | (circle) work/cell phone/pager # ( )

City | Prov. | Postal Code | Email Address

2. SPOUSAL INFORMATION

Surname of Spouse or Former Spouse | First Name | Initials

3. OPTION 1 — COVERAGE AFTER RELEASE (CAR) - CONTINUE FULL AMOUNT OR PARTIAL AMOUNT

Insured Member	Insured Spouse
Continue Full Amount: _____	Continue Full Amount: _____
or Continue Partial Amount*: _____	or Continue Partial Amount*: _____

I elect to extend Coverage After Release (CAR) beyond the certificate anniversary date for the insured person(s) indicated above. In doing so, I understand that the full life insurance coverage in force will remain in force unless subsequently modified by me; that there are no dismemberment or Waiver of Premium benefits available beyond age 65; and that no paid-up certificate will be subsequently available or issued. I also understand that, if coverage is maintained to age 74, all coverage will terminate automatically on the insured person's seventy-fifth (75th) birthday.

4. OPTION 2 — INSURANCE FOR RELEASED MEMBERS (IRM) - TRANSFER FULL AMOUNT OR PARTIAL AMOUNT

Insured Member	Insured Spouse
Transfer Full Amount: _____	Transfer Full Amount: _____
or Transfer Partial Amount*: _____	or Transfer Partial Amount*: _____

I elect to transfer the portion of my current Coverage After Release (CAR) life insurance, as indicated above, to the Insurance for Released Members (IRM) Plan. In doing so, I understand that the amount of CAR coverage I have elected to transfer as of the date this form is signed will continue in force under the IRM Plan unless subsequently modified by me. I also understand that there are no Waiver of Premium Benefits and no Paid Up Certificates available or issued under the IRM Plan, and as such, any claim I may have had for either Waiver of Premium Benefits or a Paid Up Certificate under the portion of CAR coverage I am electing to transfer, will cease to exist on the date this form is received. I also understand that, where I elect to maintain coverage on an insured person for the maximum duration under the IRM Plan, such coverage will terminate automatically on the insured person's seventy-fifth (75th) birthday.

5. OPTION 3 — RECEIVE A PAID-UP CERTIFICATE (PUC)

I elect to receive a PUC valued at 10% of my coverage in effect after any continuations/transfers* are actioned.

☐ CAR—Member $ _____ ☐ CAR—Spouse $ _____

If you are transferring any or all of your coverage to IRM, you must complete the Beneficiary Designation below. The beneficiary(ies) for any CAR coverage not transferred to IRM will remain the same.

6a. MEMBER COVERAGE—BENEFICIARY DESIGNATION

As the certificate holder , I hereby designate the following beneficiary(ies) for my IRM coverage. This beneficiary designation is revocable unless stated otherwise.
Note: The designation of a spouse as beneficiary for Life Insurance by a member who **became a participant** while residing in the Province of Quebec, may be irrevocable if the member did not specify it to be revocable. In such a case a change of beneficiary cannot be made without the spouse's **written** permission . If you know this to be relevant in your case, please have your spouse sign Block 8 "**Release of Beneficiary**" .

	Name (in full) of Persons or Institutions	Relationship to Certificate Holder	If Minors, Date of Birth * Day/Month/Year	Percentage of Proceeds (Indicate if Equal Shares)
Primary				%
Primary				%
Primary				%

(List Member's Contingent Beneficiaries on next page)

Service Number (SN):

6b. MEMBER COVERAGE—BENEFICIARY DESIGNATION (Continued)

In the event of death of the Primary Beneficiary(ies):

	Name (in full) of Persons or Institutions	Relationship to Certificate Holder	If Minors, Date of Birth* Day/Month/Year	Percentage of Proceeds (Indicate if Equal Shares)
Contingent				%
Contingent				%
Contingent				%
Contingent				%

*With respect to the minor child(ren) designated above, I appoint the following as trustee(s) to receive any proceeds under my plan. Please provide the name, relationship, current address and phone number of the trustee(s). **If this does not apply, please indicate n/a.**

TRUSTEE(S): _____

7. SPOUSAL COVERAGE—BENEFICIARY DESIGNATION ☐ Contingents & Trustee(s) same as member, or

As the certificate holder , I hereby designate the following beneficiary(ies) for my IRM coverage. This beneficiary designation is revocable unless stated otherwise.

	Name (in full) of Persons or Institutions	Relationship to Certificate Holder	If Minors, Date of Birth * Day/Month/Year	Percentage of Proceeds (Indicate if Equal Shares)
Primary	Always the member unless named otherwise	Member		100 %

In the event of death of the Primary Beneficiary(ies):

	Name (in full) of Persons or Institutions	Relationship to Certificate Holder	If Minors, Date of Birth* Day/Month/Year	Percentage of Proceeds (Indicate if Equal Shares)
Contingent				%
Contingent				%
Contingent				%

TRUSTEE(S): _____

8. RELEASE OF BENEFICIARY (Please see note in Block 6a.)

The undersigned, being the present full or partial beneficiary for the members life insurance coverage with SISIP Financial, hereby relinquishes all right, title, and interest as beneficiary.

Dated at _____ this_____day of _____, 20_____
Location Month

_____ _____
Witness (other than Certificate Holder) Irrevocable Beneficiary

9. SIGNATURE

Declaration and Authorization by Applicant

I certify that all information I have provided in this form is true and complete. **I authorize** Manulife, its reinsurers as necessary, and SISIP Financial to collect, use, maintain and disclose personal information (collectively) "Information" relevant to this insurance coverage for the purposes of Group Insurance plan administration, underwriting, audit and the assessment, investigation and management of any claim under this coverage (collectively) the "Purposes". **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrators, insurers, investigative agency and any administrators of other benefits program to collect, use, maintain and exchange this Information with each other and with Manulife, its reinsurers and/or its service providers, and SISIP Financial, for the Purposes.

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Insurance plan health file. Access to your information will be limited to:

> Manulife employees, representatives, reinsurers, service providers and SISIP Financial in the performance of their jobs;
> Persons to whom you have granted access; and
> Persons authorized by law.

The information provided on this form is protected from unauthorized disclosure under Canada's *Privacy Act* . You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

_____ _____ _____ _____
Member's Signature Day Month Year Spouse's Signature Day Month Year

Please return completed form to: Manulife , SISIP Services, 2727 Joseph Howe Drive, PO Box 1030, Halifax, NS B3J 2X5

Manulife Financial Office Use Only

Verified by: _____ _____
Day Month Year