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FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Insurance for Released Members (IRM)

(term life insurance to age 75)

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

1. INSURANCE NEEDS ANALYSIS (INA)

Purchasing life insurance is a crucial component of your overall financial security plan. SISIP Financial requires each applicant to complete an **Insurance Needs Analysis (INA)** at the time of application. Completing an INA will help ensure you understand your current life insurance needs and make an informed decision regarding your coverage. To complete an INA, contact SISIP Financial.

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

Initiate coverage under: ☐ IRM-M ☐ IRM-S

Increase coverage under: ☐ IRM-M ☐ IRM-S

Decrease coverage under: ☐ IRM-M ☐ IRM-S

3. ADMINISTRATIVE INFORMATION:

1. Is/was your spouse or former spouse a CAF member?

Yes ☐ No ☐ N/A ☐

If "yes", indicate name and Service Number of person. **and SN:**

Note: Maximum total insurance coverage on any one person, through individual and spousal coverage, cannot exceed **$1,200,000.**

4. IMPORTANT NOTES

1. To **transfer** eligible coverage to IRM at time of release, a member **MUST APPLY** within **60 days of their release date**. The **Health Questionnaire**, Block 12, is **NOT** required.
2. To **initiate or increase** IRM coverage, the member or his spouse **must be less than** 66 years of age. The **Health Questionnaire**, Block 12, must be completed. Please note that a medical examination may be required. If required a medical form will be sent with the necessary instructions.
3. If the amount eligible for transfer exceeds **$1,200,000**, the balance may be converted to an individual policy with Manulife.

5. MEMBER INFORMATION

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

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

Date of Release (DOR) (dd-mm-yyyy) | *Primary/Day Telephone* | *Secondary/ Evening Telephone*

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

Province | *Postal Code* | *Email Address*

6. SPOUSAL INFORMATION (IF APPLYING FOR SPOUSAL COVERAGE, INCREASE, DECREASE OR A TRANSFER)

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

Surname | *First Name* | *Initials* | *Maiden Name (if applicable)* | *M* ☐ *F* ☐

Mailing address same as above: ☐
Only enter mailing address if different from member:

Date of Birth (dd-mm-yyyy) | *Date of Marriage (if applicable) (dd-mm-yyyy)*

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

Province | *Postal Code* | *Email Address*

7. PREMIUMS* PER AGE GROUP

MONTHLY	*Under 25*	*25 - 29*	*30 - 34*	*35 - 39*	*40 - 44*	*45 - 49*	*50 - 54*	*55 - 59*	*60 - 64*	*65 - 69*	*70 - 74*
Non-Smoker Rate / $10,000	$0.75	$0.65	$0.70	$0.85	$1.10	$1.40	$2.10	$3.55	$6.30	$11.55	$24.35
Smoker Rate / $10,000	$1.10	$1.00	$1.15	$1.30	$1.90	$3.15	$5.40	$8.95	$15.75	$26.25	$50.90

*The insurer retains the right to change the premium amounts under this policy, from time to time, without prior notice to the member.

8. SMOKING/NON-SMOKING STATUS

Have you used tobacco or a tobacco product in the last twelve (12) months?

CAF Member (M): YES ☐ NO ☐ **Spouse (S):** YES ☐ NO ☐

SN:

9. MEMBER COVERAGE

If Total Coverage Requested is more than **$250,000**, see **Block 1 INSURANCE NEEDS ANALYSIS** on Page 1

Life insurance is available in increments of $10,000 to a maximum of **$1,200,000**.

$	+	$	=	$ 0	÷ $10,000 =	0	×		=	
Coverage in Effect		(+/-) Change in Coverage		Total Coverage Requested		# of Units		Monthly Rate		Monthly Premium

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 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 5) and spouse (Block 6) 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 in relation to my foregoing coverage 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			Percentage
☒ PRIMARY			dd	mm	yyyy	%
☐ PRIMARY ☐ CONTINGENT			dd	mm	yyyy	%
☐ PRIMARY ☐ CONTINGENT			dd	mm	yyyy	%

TRUSTEE/TUTOR | Address and telephone #:

10. SPOUSAL COVERAGE

If Total Coverage Requested is more than **$250,000**, see **Block 1 INSURANCE NEEDS ANALYSIS** on Page 1

Life insurance is available in increments of $10,000 to a maximum of **$1,200,000**.

$	+	$	=	$ 0	÷ $10,000 =	0	×		=	
Coverage in Effect		(+/-) Change in Coverage		Total Coverage Requested		# of Units		Monthly Rate		Monthly Premium

Note 1: The primary beneficiary for IRM-SPOUSAL is always the applicant per Block 5 (the Member), unless otherwise stated in writing by the applicant (Member). If a primary beneficiary, other than the applicant (Member), is to be named, the PRIMARY box is to be ticked and information completed accordingly. 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 in relation to my foregoing coverage and hereby designate the following beneficiary(ies).

This beneficiary designation is revocable unless stated otherwise.

If spousal contingent beneficiaries and/or the Trustee/Tutor are exactly the same as the Member's, tick here: ☐
You are, therefore, not required to complete this section.

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

TRUSTEE/TUTOR | Address and telephone #:

11. SUMMARY OF PREMIUM REQUIRED (SEE BLOCKS 9 AND 10)

I elect to pay premiums:

a) ☐ monthly through the "pre-authorized debit (PAD) agreement" by completing Block 13; 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 11, payable to Manulife 60 days after my release date. I will be invoiced annually thereafter.

Monthly Premium Block 9 + Monthly Premium Block 10	$ 0.00	**Total Monthly Premium**	$ 0.00
Enter provincial tax rate*: *(MB-RST, ON-RST, QC-QST, others 0%)	0.00% %	Total Monthly Premium × 12 Months = **Total Annual Premium**	
RST/QST (if applicable*)	$ 0.00		**$ 0.00**

12. HEALTH QUESTIONNAIRE - ONLY COMPLETE TO INITIATE AND/OR INCREASE COVERAGE

NOTE: All "Yes" responses in questions 1 to 6 require detailed information in the Health Questionnaire - Details Section. If additional space is needed, use a separate sheet providing the information required including your name, service number (SN), signature and date and attach it to this application.

1. Have you had, been told you have, or received treatment, medication, advice or counseling for any disease or disorder of:

		Member (M)		Spouse (S)				Member (M)		Spouse (S)	
		YES	NO	YES	NO			YES	NO	YES	NO
1.1	**Heart** (high blood pressure, high cholesterol, chest pain, heart attack, transient ischemic attack (TIA), heart murmur, stroke, etc.)	☐	☐	☐	☐	1.8	**Sexually transmitted infection**	☐	☐	☐	☐
1.2	**Cancer** (including abnormal paps, tumors)	☐	☐	☐	☐	1.9	**Alcohol abuse**	☐	☐	☐	☐
1.3	**Ulcer, intestine** (colitis, Crohn's, polyps, etc.)	☐	☐	☐	☐	1.10	**Disease or disorder of the blood**	☐	☐	☐	☐
1.4	**Endocrine conditions** (diabetes, impaired glucose tolerances, thyroid, etc.)	☐	☐	☐	☐	1.11	**Disease or disorder of the lungs** (including asthma)	☐	☐	☐	☐
1.5	**Neurological** (epilepsy, MS, ALS, etc.)	☐	☐	☐	☐	1.12	**Disease or disorder of the liver** (hepatitis, etc.)	☐	☐	☐	☐
1.6	**Joint, limbs and spine**	☐	☐	☐	☐	1.13	**Disease or disorder of the pancreas**	☐	☐	☐	☐
1.7	**Mental or nervous condition** (anxiety, depression, PTSD, etc.)	☐	☐	☐	☐	1.14	**Disease or disorder of the kidneys**	☐	☐	☐	☐
						1.15	**Disease or disorder of the urine**	☐	☐	☐	☐

SN: _____

	Member (M)		Spouse (S)	
	YES	NO	YES	NO
2. Have you been told that you had any immune deficiency disorder, including AIDS or AIDS related complex (ARC), or any generalized enlargement of your lymph glands, or any test results indicating possible exposure to the AIDS virus (e.g., HIV, HTLV-III, LAV)?	☐	☐	☐	☐
3. At any time, in the last five years, have you consulted a physician, or health care practitioner for any disease, ailment, injury or condition, including mental health, not already disclosed?	☐	☐	☐	☐
4. Do you have any health conditions for which further treatment, examination, diagnostic test(s) or surgery has been advised or contemplated?	☐	☐	☐	☐
5. Are you taking any prescribed medications? **If "Yes", list current medications and dosage in the details section below.**	☐	☐	☐	☐
6. Are you aware of any symptoms or complaints regarding your health?	☐	☐	☐	☐
7. Have you used in any form: cannabis, tobacco or nicotine products? **If you answer "Yes", please provide details immediately below:**	☐	☐	☐	☐

Member (M)	**Product #1**	**Product #2**	**Product #3**
Product form:			
Avg Consumption: *Enter amount & rate: 1 pack/day, 5 g/week, etc.*			
Total years of use:			
Last used:			

Spouse (S)	**Product #1**	**Product #2**	**Product #3**
Product form:			
Avg Consumption: *Enter amount & rate: 1 pack/day, 5 g/week, etc.*			
Total years of use:			
Last used:			

8. Have you used drugs not prescribed to you: cocaine, LSD, narcotics, amphetamines, anabolic steroids or others?
If you answer "Yes", please provide details immediately below:

(M) YES ☐ NO ☐ **(S)** YES ☐ NO ☐

Member (M)	**Product #1**	**Product #2**	**Product #3**
Product form:			
Avg Consumption: *Enter amount & rate per day, per week, etc.:*			
Total years of use:			
Last used:			

Spouse (S)	**Product #1**	**Product #2**	**Product #3**
Product form:			
Avg Consumption: *Enter amount & rate per day, per week, etc.:*			
Total years of use:			
Last used:			

9. Have you had an application for life, health or disability insurance declined, postponed or modified in any way?
If you answer "Yes", please provide details immediately below:

(M) YES ☐ NO ☐ **(S)** YES ☐ NO ☐

Member (M)
Insurer: _____ *dd* | *mm* | *yyyy*
Reason: _____

Spouse (S)
Insurer: _____ *dd* | *mm* | *yyyy*
Reason: _____

10. **Member (M)**
Height: cm: _____ or ft./in.: _____
Weight: kg: _____ or lb: _____

11. **Spouse (S)**
Height: cm: _____ or ft./in.: _____
Weight: kg: _____ or lb: _____

12. **Member (M):** Name, address and telephone number of your regular Physician or clinic holding your medical documents:
Name: _____ Telephone: _____
Address: _____

13. **Spouse (S):** Name, address and telephone number of your regular Physician or clinic holding your medical documents:
Name: _____ Telephone: _____
Address: _____

14. Please complete the following information about your last medical visit:

Patient	**Date of Last Visit** *mm*	*yyyy*	**Reason for Visit**	**Name and address of Physician or clinic**
Member (M)				
Spouse (S)				

Health Questionnaire - Details Section:

Note: If you answered "YES" in any question from 1 to 6 above please provide details: If additional space is needed, use a separate sheet providing the information required including your name, service number (SN), signature and date and attach it to this application.

Question Number (1 to 6)	**M or S**	**Details, Diagnosis, Duration, Results**	**Date Treated** *mm*	*yyyy*	**Treatment & Results**	**Name and address of Physician or clinic**

SN:

13. PRE-AUTHORIZED DEBIT (PAD) AGREEMENT (if applicable, see Block 11)

While the PAD is in effect, SISIP Financial and/or Manulife will not give notice of the premiums falling due. All provisions of SISIP Financial Policy #901102 relating to the payment or non-payment of premiums shall apply to the PAD.

SISIP Financial may change their rates, from time to time, and this authorization to deduct the associated monthly premiums shall remain in force until revoked by me, or by SISIP Financial, in writing. This notification must be received at least twenty (20) business days before the next debit.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement.

I may obtain a sample cancellation form; more information on my right to cancel a PAD agreement; or, more information on my recourse rights by contacting my financial institution or visiting www.cdnpay.ca.

If there are more than two failed transactions in any twelve (12) month period, SISIP Financial and/or Manulife may terminate the PAD and invoice the undersigned for annual payments in advance.

PLEASE COMPLETE THE FOLLOWING:

1. Type of account: ☐ **Chequing or** ☐ **Savings AND** ☐ **Personal or** ☐ **Business**

2. Day of the month to be withdrawn: ☐ **1st of the month** ☐ **15th of the month**

3. Depositor(s)' name(s) as shown on bank records printed:

4. Depositor(s)' signature(s) as shown on bank records:

	dd	mm	yyyy

5. Bank number (3 digits): _____ **Branch number (up to 5 digits):** _____

Account number (7-12 digits): _____**; or, attach a VOID cheque or bank produced PAD form.**

14. 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 Insurance for Released Members option 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, NS 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.

I hereby authorize a deduction from my pay account in payment of the SISIP Financial premiums at such rate as may from time to time be authorized.

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.

SAVE AS

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**

15. 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** ☐

16. APPROVING AUTHORITY (to be completed by SISIP Financial or 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: LTD ☐ SIB ☐ IRM (M) _____ IRM (S) _____ GOIP (Basic) ☐ GOIP (Optional) ☐

dd *mm* *yyyy* *SISIP Financial* **OR** *dd* *mm* *yyyy* *Manulife*