

Regular Force Optional Group Term Insurance (OGTI)

Mail to:
SISIP Financial
4210 Labelle Street, Ottawa, ON K1A 0K2
1-800-267-6681 | 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)

<input type="checkbox"/> Initiate coverage under:	OGTI-Member <input type="checkbox"/>	OGTI-Spousal <input type="checkbox"/>	General Officers' Insurance Plan (GOIP) – Basic <input type="checkbox"/>	General Officers' Insurance Plan (GOIP) – Optional <input type="checkbox"/>
<input type="checkbox"/> Increase coverage under:	OGTI-Member <input type="checkbox"/>	OGTI-Spousal <input type="checkbox"/>		
<input type="checkbox"/> Decrease coverage under:	OGTI-Member <input type="checkbox"/>	OGTI-Spousal <input type="checkbox"/>		
<input type="checkbox"/> Transfer Survivor Income Benefit (SIB*) to OGTI-Member (to a maximum amount of 50x monthly salary rounded to the next higher multiple of \$10,000)				
<input type="checkbox"/> Transfer Spousal-Dependent Life to OGTI-Spousal (to a maximum 2 units): Yes <input type="checkbox"/> No <input type="checkbox"/>				
<input type="checkbox"/> Transfer to OGTI from: Reserve Term Insurance Plan (RTIP) <input type="checkbox"/> Insurance for Released Members (IRM) <input type="checkbox"/> Coverage After Release (CAR) <input type="checkbox"/>				
<input type="checkbox"/> Change beneficiary				
<input type="checkbox"/> Change status to: Married <input type="checkbox"/> Common Law <input type="checkbox"/> Single <input type="checkbox"/> Separated* <input type="checkbox"/> Divorced <input type="checkbox"/> Single Parent <input type="checkbox"/>				

*For SIB only: complete and sign the Separation / Reconciliation Declaration form (4E) and attach it to this application.

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**

2. Complete if you are leaving your home unit for a theatre of operations:

Departure
(dd-mm-yyyy)

Expected return
(dd-mm-yyyy)

4. MEMBER INFORMATION

Service Number (SN)		CFOne #		Rank	
Date of Birth (dd-mm-yyyy)	Surname	First Name	Initials	M <input type="checkbox"/>	F <input type="checkbox"/>
Date of Enrollment (DOE) (dd-mm-yyyy)	Primary/Day Telephone		Secondary/ Evening Telephone		
Apt.	Civic #	Street		City	
Province	Postal Code	Email Address			

5. 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 <input type="checkbox"/>	F <input type="checkbox"/>
Mailing address same as above: <input type="checkbox"/>		Date of Birth (dd-mm-yyyy)	Date of Marriage (if applicable) (dd-mm-yyyy)		
Apt.	Civic #	Street		City	
Province	Postal Code	Email Address			

6. 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.

7. MEMBER COVERAGE If Total Coverage Requested is more than **\$250,000**, see **Block 1 INSURANCE NEEDS ANALYSIS** on Page 1Life insurance is available in increments of \$10,000 to a maximum of **\$1,200,000**.

\$ <input type="text"/>	+	\$ <input type="text"/>	=	<input type="text"/>	÷ \$10,000 =	<input type="text"/>	×	<input type="text"/>	=	<input type="text"/>
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 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 4) and spouse (Block 5) 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
<input type="checkbox"/> PRIMARY	<input type="text"/>	<input type="text"/>	dd	mm	yyyy	<input type="text"/>
<input type="checkbox"/> PRIMARY	<input type="text"/>	<input type="text"/>	dd	mm	yyyy	<input type="text"/>
<input type="checkbox"/> CONTINGENT	<input type="text"/>	<input type="text"/>	dd	mm	yyyy	<input type="text"/>
<input type="checkbox"/> PRIMARY	<input type="text"/>	<input type="text"/>	dd	mm	yyyy	<input type="text"/>
<input type="checkbox"/> CONTINGENT	<input type="text"/>	<input type="text"/>	dd	mm	yyyy	<input type="text"/>
TRUSTEE/TUTOR	<input type="text"/>	Address and telephone #:	<input type="text"/>			

8. SPOUSAL COVERAGE If Total Coverage Requested is more than **\$250,000**, see **Block 1 INSURANCE NEEDS ANALYSIS** on Page 1Life insurance is available in increments of \$10,000 to a maximum of **\$1,200,000**.

\$ <input type="text"/>	+	\$ <input type="text"/>	=	<input type="text"/>	÷ \$10,000 =	<input type="text"/>	×	<input type="text"/>	=	<input type="text"/>
Coverage in Effect		(+/-) Change in Coverage		Total Coverage Requested		# of Units		Monthly Rate		Monthly Premium

Note 1: The primary beneficiary for OGTI-SPOUSAL is always the applicant per Block 4 (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
<input type="checkbox"/> PRIMARY	<input type="text"/>	<input type="text"/>	dd	mm	yyyy	<input type="text"/>
<input type="checkbox"/> CONTINGENT	<input type="text"/>	<input type="text"/>	dd	mm	yyyy	<input type="text"/>
<input type="checkbox"/> PRIMARY	<input type="text"/>	<input type="text"/>	dd	mm	yyyy	<input type="text"/>
<input type="checkbox"/> CONTINGENT	<input type="text"/>	<input type="text"/>	dd	mm	yyyy	<input type="text"/>
TRUSTEE/TUTOR	<input type="text"/>	Address and telephone #:	<input type="text"/>			

9. 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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1.8 Sexually transmitted infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2 Cancer (including abnormal paps, tumors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1.9 Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3 Ulcer, intestine (colitis, Crohn's, polyps, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1.10 Disease or disorder of the blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4 Endocrine conditions (diabetes, impaired glucose tolerances, thyroid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1.11 Disease or disorder of the lungs (including asthma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5 Neurological (epilepsy, MS, ALS, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1.12 Disease or disorder of the liver (hepatitis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.6 Joint, limbs and spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1.13 Disease or disorder of the pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.7 Mental or nervous condition (anxiety, depression, PTSD, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1.14 Disease or disorder of the kidneys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					1.15 Disease or disorder of the urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have any health conditions for which further treatment, examination, diagnostic test(s) or surgery has been advised or contemplated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you taking any prescribed medications? If "Yes", list current medications and dosage in the details section below.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Are you aware of any symptoms or complaints regarding your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you used in any form: cannabis, tobacco or nicotine products? If you answer "Yes", please provide details immediately below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Member (M)	Product #1	Product #2	Product #3	Spouse (S)	Product #1	Product #2	Product #3
Product form:				Product form:			
Avg Consumption: <i>Enter amount & rate: 1 pack/day, 5 g/week, etc.</i>				Avg Consumption: <i>Enter amount & rate: 1 pack/day, 5 g/week, etc.</i>			
Total years of use:				Total years of use:			
Last used:				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 <input type="checkbox"/> NO <input type="checkbox"/>	(S) YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	--

Member (M)	Product #1	Product #2	Product #3	Spouse (S)	Product #1	Product #2	Product #3
Product form:				Product form:			
Avg Consumption: <i>Enter amount & rate per day, per week, etc.</i>				Avg Consumption: <i>Enter amount & rate per day, per week, etc.</i>			
Total years of use:				Total years of use:			
Last used:				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 <input type="checkbox"/> NO <input type="checkbox"/>	(S) YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	--

Member (M) Insurer: _____ Reason: _____	dd	mm	yyyy	Spouse (S) Insurer: _____ Reason: _____	dd	mm	yyyy
--	----	----	------	--	----	----	------

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 <i>mm yyyy</i>	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 <i>mm yyyy</i>	Treatment & Results	Name and address of Physician or clinic

SN: **10. 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 ☐**11. 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.**

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:

- 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;
- to disclose only the necessary personal information it has relating to me to these same persons and organizations, specified in paragraph (a); or,
- 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.

CAF Member's Name Printed: CAF Member's Signature: dd mm yyyyI consent to being notified or contacted regarding other SISIP Financial products or services: Initial: YES or NOSpouse'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**12. 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 yyyyWas an Insurance Needs Analysis (INA) completed (initial): YES ☐ NO ☐**13. APPROVING AUTHORITY** (to be completed by SISIP Financial or Manulife)

The Member insurance coverage is: Cancelled ☐ Postponed _____ year(s) ☐ Denied ☐ ☐ Approved Allotment effective: dd mm yyyy

The Spousal insurance coverage is: Cancelled ☐ Postponed _____ year(s) ☐ Denied ☐ ☐ Approved Allotment effective: dd mm yyyy

The current coverage in force is: LTD ☐ SIB ☐ OGTI (M) OGTI (S) GOIP (Basic) ☐ GOIP (Optional) ☐

dd mm yyyy SISIP Financial OR dd mm yyyy Manulife

14. FOR SISIP FINANCIAL OFFICE USE Sent to Manulife on dd mm yyyy M ☐ S ☐LTD ☐ S2 S3 S4 SE-O SE-B ☐**Allotment Advice**

Pay Allotment Code	Effective Date of Allotment dd mm yyyy	Premium	Voucher #	dd-mm-yyyy

Actioned by dd mm yyyy