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FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Simplified Issue Term Life Insurance Application

(term life insurance for up to $100,000 in coverage)

As an immediate response to the coronavirus situation, this form for Simplified Issue Term Life Insurance is a time limited form.

1. ELIGIBILITY

1. You must not be under the care of a medical professional, planning or undergoing medical investigations, or experiencing signs/symptoms for which you have, should have or will be seeking the advice of a medical professional
2. This application is valid for requests of up to $100,000, if you require more than $100,000 of coverage, a complete term life insurance application, 1E, is required. Speak to your SISIP Financial Insurance Advisor or go to cfmws.ca/insurance-finance/resources/forms.

2. THIS APPLICATION IS FOR

- ☐ I am a Regular Force member (OGTI-M coverage)
- ☐ I am a Primary Reserve Force member (RTIP-M coverage)
- ☐ I am a Spouse of a Regular Force member (OGTI-S coverage)
- ☐ I am a Spouse of a Primary Reserve Force member (RTIP-S coverage)

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:**

4. 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*

5. SPOUSAL INFORMATION (IF APPLYING FOR SPOUSAL COVERAGE)

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*

6. EMAIL CONSENT

I authorize SISIP Financial and/or Manulife to correspond with me using this email address and authorize SISIP Financial and/or Manulife to send information artifacts, including protected documents, via an unencrypted and / or encrypted email. I understand that any email communication and document transmission with SISIP Financial and/or Manulife may contain personal information including but not limited to medical and financial information.

I understand that email exchanges are not a secure form of communication and that confidentiality and security cannot be ensured.

I understand that my consent may be revoked or changed, including any change in the email address to which documents are delivered, at any time by notifying SISIP or Manulife.

YES ☐ NO ☐

SN:

7. PREMIUMS* PER AGE

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 ☐

9. MEMBER COVERAGE (If Total Coverage Requested is more than $100,000, see Block 1 on Page 1)

Reset this Block

Life insurance is available in increments of $10,000 to a maximum of **$100,000**.

$	+	$	=	$ 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 this Group Policy No. 901102 while a resident 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 may name any person(s) and/or organization(s) to be their beneficiary. If more than one primary beneficiary is to be named, select 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. Select 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 coverages 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 #:

The appointment of a Trustee is not permissible in Quebec

10. SPOUSAL COVERAGE (If Total Coverage Requested is more than $100,000, see Block 1 on Page 1)

Life insurance is available in increments of $10,000 to a maximum of $100,000.

$	+	$	=	$ 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 OGTI/RTIP-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 selected and information completed accordingly. If more than one primary beneficiary is to be named, select 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. Select 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, check 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 #:

The appointment of a Trustee is not permissible in Quebec

SN:

11. (only completed by Reservists when applying for RTIP) - PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

I authorize Manulife to withdraw, until further written notice from me or my duly authorized representative, all premium payments ("Payments") due in relation to the coverage, from the bank account identified on the attached void cheque, or the bank account I have identified in this application (both referred to herein as the "Account"), whichever is applicable, on or about the first business day or 15th business day, as applicable, of each month in which Coverage premiums are due. I also understand and agree that either Manulife or I may, at any time upon written notice, discontinue the direct withdrawal of Payment(s), from my Account, in which case Manulife shall be entitled to require another method of payment, acceptable to Manulife. The terms and conditions of this pre-authorized collection authorization shall apply to the Accounts herein names by me and any other Accounts I choose to name in the future, and shall remain valid for the duration of my Coverage or until revoked by me in writing. I agree that if I have asked Manulife to debit my bank account for a Pre-Authorized Debit (PAD) plan (Funds Transfer PAD), I authorize the bank or other financial institution I have named to honour my instructions. I understand that 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, 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. Account Holder(s)' name(s) as shown on bank records printed:

4. Signature of Account Holder as shown on bank records: dd / mm / yyyy

5. Signature of second Account Holder as shown on bank records, if joint: dd / mm / yyyy

6. 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.**

12. DECLARATION

By signing the Signature block (Block #13) of this Application:

• I understand and declare that for me, the Employee, to qualify for coverage up to $100,000, without completing a detailed medical questionnaire, **I must be in good health and I do not have any physical or mental condition(s) that prevent me from regularly attending to my occupation**; and:

• I declare that **I have never been declined or postponed coverage** that I have either applied for or been the subject of any application for life insurance coverage with any insurer, or other entity, and:

• I understand that, if this application is approved, no Employee Optional Life Insurance will be paid for any Non-Evidence Limit amount when the death of the Employee is directly or indirectly attributable to a **"Pre-Existing" Condition during the first 24 months of insurance**, and;

• A "Pre-existing" Condition means an illness or injury for which, during the 24 months prior to the date the Employee's insurance under this benefit became effective, or the latest date of reinstatement of insurance on such Employee, whichever is applicable, **the Employee has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic investigations), consulted a Physician or any health care practitioner or has been prescribed medication**; or where treatment would have been sought by a prudent individual during the twenty four (24) months prior to the date the Employee's insurance under this benefit became effective.

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

Note 1: For further details regarding the completion of this form please contact SISIP Financial at 1-800-267-6681

Note 2: Forward your completed application form to: RTIP applications send to SISIP.RTIP@CFMWS.COM
OGTI applications send to SISIP.OGTI@CFMWS.COM

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, 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 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 I am 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 / 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

SN:

14. 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** ☐

15. APPROVING AUTHORITY (to be completed by SISIP Financial or Manulife)

The Member insurance coverage is: ☐ Cancelled ☐ Denied ☐ Approved

The Spousal insurance coverage is: ☐ Cancelled ☐ Denied ☐ Approved

The current coverage in force is: **LTD** ☐ **SIB** ☐

OGTI (M) _____ OGTI (S) _____ GOIP (Basic) ☐ GOIP (Optional) ☐

RTIP (M) _____ RTIP (S) _____ RES GOIP (Basic) ☐ RES GOIP (Optional) ☐

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

Allotment Advice

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

Actioned by _____ *dd* / *mm* / *yyyy*