FINANCIÈRE SISIP FINANCIAL

A division of CFMWS
Une division des SBMFC

Life Insurance Coverage Transfer

ɪɪɪ Manulife

1. MEMBER INFORMATION

Service Number (SN)		CFOne #		Rank	

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

Apt.	Civic #	Street	City

Province	Postal Code	Email Address

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

2. COVERAGE TRANSFER INSTRUCTIONS

Note 1: For rates, please consult the application form found at SISIP.com. Sales tax may be applicable.
Note 2: Life insurance is available in increments of $10,000 to a maximum of $1,200,000.
Note 3: If transferring to the Supplementary Reserve, please transfer coverage to Insurance For Released Members (IRM).
I hereby authorize the following change(s) to my plan (check all that apply):

Member	☐ Transfer **the _full_ amount** of existing life insurance coverage to:	☐ OGTI ☐ RTIP ☐ IRM
	☐ Transfer **a _reduced_ amount of** existing life insurance coverage; _____ to:	
Spouse	☐ Transfer **the _full_ amount** of existing life insurance coverage to:	☐ OGTI ☐ RTIP ☐ IRM
	☐ Transfer **a _reduced_ amount of** existing life insurance coverage; _____ to:	

3. SPOUSAL INFORMATION

Service Number (SN)		CFOne #		Rank	

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

4. MEMBER OR DEEMED MEMBER – BENEFICIARY DESIGNATION

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 1) and spouse (Block 3) 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 under the Group Policy No. 901102 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	dd	mm	yyyy	Percentage
☐ PRIMARY			dd	mm	yyyy	
☐ PRIMARY ☐ CONTINGENT			dd	mm	yyyy	
☐ PRIMARY ☐ CONTINGENT			dd	mm	yyyy	
☐ PRIMARY ☐ CONTINGENT			dd	mm	yyyy	
TRUSTEE/TUTOR		Address and telephone #:				

5. SPOUSAL – BENEFICIARY DESIGNATION

Note 1: The primary beneficiary is always the applicant per Block 1 (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 insured, I hereby revoke any previous beneficiary designation(s) which I may have made under the Group Policy No. 901102 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	dd	mm	yyyy	Percentage
☐ PRIMARY ☐ CONTINGENT			dd	mm	yyyy	
☐ PRIMARY ☐ CONTINGENT			dd	mm	yyyy	
☐ PRIMARY ☐ CONTINGENT			dd	mm	yyyy	
☐ PRIMARY ☐ CONTINGENT			dd	mm	yyyy	
TRUSTEE/TUTOR		Address and telephone #:				

6. PAYMENT OPTIONS

Please check payment option, provide the required information, sign and date where indicated.

☐ **Option 1:** Payroll deductions (Regular Force members only)

☐ **Option 2:** Pension deduction.   Pension #: _____

I hereby authorize Procurement Canada to deduct the associated monthly premiums from my Canadian Forces Superannuation Act (CFSA) pension.

☐ **Option 3:** Pre-authorized Debit Agreement (PAD).

PAD for Released and Serving members (attach a VOID cheque; or, bank stamped form; or, provide required information). 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
	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.**

☐ **Option 4:**

Annually, I will receive an invoice, and in turn, will issue either a cheque, bank draft, or money order payable to Manulife for the yearly premium in full.

7. 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:

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.

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

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

8. MAILING INSTRUCTIONS

For payroll deduction method Option 1: Please return to:
SISIP Financial
4210 Labelle Street
Ottawa, ON K1A 0K2

For payment method Options 2, 3, and 4: Please return to:
SISIP Life Insurance – Manulife
P.O. Box 1030, 2727 Joseph Howe Drive
Halifax, NS B3J 2X5

9. SISIP FINANCIAL REPRESENTATIVE who assisted in the completion of and/or reviewed this form

Name	Signature	dd	mm	yyyy	Branch

10. FOR SISIP FINANCIAL OFFICE USE – ALLOTMENT ADVICE

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

Actioned by		dd	mm	yyyy