

# IMPORTANT

**If the beneficiary(ies) you designate is not financially dependent upon you, and you request more than \$250,000 of coverage, you will be required to meet with a SISIP FS insurance representative.**



**6. Medical History**

PROTECTED "B" (when completed)

**NOTE: Include previously declared medical conditions. Give details for any "YES" answer. If more space is required, attach a separate sheet to indicate applicability to Member (Mb) or Spouse (Sp), SN, Rank, Name, question number and details. Sign and date the attachment.**

		Member Yes No		Spouse Yes No
1. Name and address of regular Attending Physician: Member:..... Spouse:.....				
2. Date and reason last consulted: Member: Day ..... Month..... Year..... Reason .....				
Spouse: Day ..... Month..... Year..... Reason .....				
3. Diagnosis, results, treatment given or medication prescribed: Member:..... Spouse:.....				
4. Present height: Member: .....M/Ft. ....cm/in Present weight.....kg .....lb Spouse: .....M/Ft. ....cm/in Present weight.....kg .....lb				
5. Was there a 10% change in weight during the past year? If yes, please explain reason: .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
Member:..... Spouse: .....				
6. Have you ever applied for insurance that was declined, postponed, rated or modified in any way? If yes, please explain: .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
7. Have you ever claimed benefits for sickness, injury or impairment? If yes, please explain .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
8. Have you ever lost days due to sickness, injury or impairment in last two years? If yes number of days lost: Member: ..... Spouse:.....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
9. Is future medical or surgical treatment for your active medical conditions being considered by your attending physician(s)? Please elaborate fully .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>

**Regarding your personal health, have you during the past FIVE YEARS:**

10. Consulted any physician or practitioner for any reason including routine or annual physical examinations or check-ups? If yes, what were the reasons?.....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
11. Submitted to an EKG, blood tests, x-rays, or other diagnostic tests ? If yes, which tests were performed? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>

**Have you ever had any of the following (circle and initial applicable condition(s)). If yes, please elaborate fully**

12. Shortness of breath, persistent hoarseness or cough, blood in sputum, bronchitis, pleurisy, asthma, emphysema, tuberculosis, or chronic respiratory disorder?.....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
13. Dizziness, fainting, convulsions, headache, speech dysfunction, paralysis or stroke, muscle weakness, incoordination, mental or nervous disorder including psychiatric illness such as: anxiety disorder, phobia, depression,etc.....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
14. Chest pain, palpitations, high blood pressure, blackout, rheumatic fever, shortness of breath overnight, heart murmur (indicate type), swelling of extremities, heart attack, exertional leg pain, or other disorder of the heart or bloods vessels? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
15. Disorder of the eyes, ears, nose, or throat? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
16. Sugar, albumin, blood or pus in urine, venereal disease (indicate type), stone or other disorder of kidney, ureters, bladder, prostate, or reproductive organs? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
17. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, haemorrhoids, recurrent indigestion or other disorder of the oesophagus, stomach, intestine, liver, or gallbladder? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
18. Diabetes, thyroid disorder including toxic goitre or other endocrine disorders? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
19. Any disorder of the musculoskeletal system (e.g., arthritis (indicate osteo or rheumatoid), gout, neuritis, sciatica, etc. including the spine, back, or joints)? ....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
20. Deformity, gait disorder, or amputation?.....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
21. Disorder of skin, lymph glands, cyst, tumour (indicate benign or malignant), or cancer .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
22. Allergies, anaemia or other disorder of the blood? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
23. Any other illness, disease or condition not listed above? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
24. Did your father, mother, or any of your brothers, sisters, before attaining age 60, ever have diabetes, high blood pressure, heart disease, nervous, or mental disorders or hereditary disorders? Please explain .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
25. Have you ever been tested for, counselled for, or told you had AIDS (Acquired Immune Deficiency Syndrome), or any other immunological disorder? Please elaborate fully .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
26. Have you ever tested positive for HIV (Human Immunodeficiency Virus)?.....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
27. Have you been immunized against the hepatitis B virus? If yes, please give year of immunization: .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>

**Have you ever:**

28. Received treatment for alcohol and/or drug use? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
29. Been charged with impaired driving, or been arrested due to the influence of alcohol and/or drugs? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
30. Used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens, or any other drugs <b>not</b> obtained by prescription? If yes, give details:.....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
31. Used tobacco products? .....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
If yes, average daily consumption: Member:..... Spouse:..... Total years of use Member:..... Spouse:.....		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>

**7. Smoking / Non-Smoking Status**

Have you smoked a cigarette in the last twelve months? CF MEMBER: YES <input type="checkbox"/> NO <input type="checkbox"/>	SPOUSE: YES <input type="checkbox"/> NO <input type="checkbox"/>
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**8. Insurance for Released Members (IRM) - Member**

PROTECTED "B" (when completed)

SN

Enter amount of insurance desired on your life, in units of \$10,000 to a maximum of \$400,000. See block 5 for premium rates.

Transfer of and/or coverage in effect	Additional coverage requested	Total coverage requested	# of Units	Rate	Monthly Premium
\$ <input type="text"/>	+ \$ <input type="text"/>	= \$ <input type="text"/>	÷ \$10,000 = <input type="text"/>	x <input type="text"/>	= \$ <input type="text"/>

I hereby revoke any previous beneficiary designations which I may have made under the Group Policy No. 901102 for IRM and hereby designate the following beneficiary(ies), reserving to myself the right to revoke such designation. See Block 1, Para 7 for further information.

Name (in full) of persons or organizations	Relationship	Percentage
Primary		100%
Contingent		
Contingent		

**NOTE:** The member may name any person(s) and/or organization(s) to be his/her beneficiary. If more than one Primary is to be named, the word Contingent is to be amended to read Primary and the desired percentage is to be shown for each beneficiary. If minor children are included, the date of birth of the children and name and address of Trustee must be shown for each one. The Contingent block allows for the naming of a secondary beneficiary in the case of death of the Primary beneficiary. If insufficient space, please complete Form 11E Designation/Change of beneficiary and staple it to this application.

**9. Insurance for Released Members (IRM) - Spousal**

Enter amount of insurance desired on your life, in units of \$10,000 to a maximum of \$400,000. See block 5 for premium rates.

Transfer of and/or coverage in effect	Additional coverage requested	Total coverage requested	# of Units	Rate	Monthly Premium
\$ <input type="text"/>	+ \$ <input type="text"/>	= \$ <input type="text"/>	÷ \$10,000 = <input type="text"/>	x <input type="text"/>	= \$ <input type="text"/>

I hereby revoke any previous beneficiary designations which I may have made under the Group Policy No. 901102 for IRM and hereby designate the following beneficiary(ies), reserving to myself the right to revoke such designation. See Block 1, Para 7 for further information

Name (in full) of persons or organizations	Relationship	Percentage
Contingent		
Contingent		

**NOTE:** The primary beneficiary for IRM - Spousal proceeds is always the applicant per Block 2. The contingent blocks above allow for the naming of a secondary beneficiary in case of the death of the primary beneficiary. If minor children are named as contingent beneficiaries, the date of birth of the children and the name and address of the trustee(s) should be shown. If insufficient space on this form, please complete Form 11E Designation/Change of beneficiary and staple to this application.

**10. Summary of Premium Required (see block 1 item 8):**

I elect to pay premiums  Monthly  Annually

Sub-Total of Monthly Premium	\$ <input type="text"/>
* PST (if applicable)	\$ <input type="text"/>
Total monthly premium	\$ <input type="text"/>
Annual Premium = Total monthly premium	\$ <input type="text"/> x 12 Months = \$ <input type="text"/>

\* Ontario residents add 8%; Quebec residents add 9%

**11. Signature Block (to be read and signed for all submissions including a change of beneficiary)**

The responses and declarations contained herein are true and complete. I realize that any material misrepresentation shall render the insurance voidable.

I hereby authorize the NDHQ/SISIP FS Office and Manulife Financial or its reinsurers, for underwriting and administration of insurance and claims paying purposes only:

- a) to gather only that information 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, 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; and
- c) to request a personal investigation report relating to me.

A photocopy 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 the President SISIP FS and/or Manulife Financial. Therefore, I understand that **NO** action should be taken to terminate existing insurance coverage(s) until notified of the decision regarding this application. It is further acknowledged that a statement regarding the release of personal information by The Medical Information Bureau has been received.

CF Member's Signature	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Day	Month	Year
Spouse's Signature	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Day	Month	Year

**12. SISIP FS Representative who assisted in the completion of this form or Point of Contact who received this form.**

Once this area is completed, this form is to be sent immediately to NDHQ/President SISIP FS

<input type="text"/>	<input type="text"/>	( <input type="text"/> ) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Unit/Location	Telephone	Day	Month	Year

**13. Approving Authority (To be completed only by SISIP FS or Manulife Financial)**

The member insurance coverage and the spousal insurance coverage is **APPROVED** effective:     
 Day Month Year

The member insurance coverage and the spousal insurance coverage is **NOT APPROVED**. SERVICE NUMBER

Therefore, the current coverage in force is: IRM (M) \$  IRM (S) \$

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NDHQ/President SISIP FS	Day	Month	Year	Group Underwriter, Manulife Financial	Day Month Year

PROTECTED "B" (when completed)



**Canadian Forces Superannuation Act  
(CFSA)  
Pension Deduction Authorization**

**1. CERTIFICATE HOLDER'S INFORMATION**

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Service Number (SN) Rank Surname First Name Initials

	( )
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Mailing Address Home Phone #

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

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City Province Postal Code

**2. PENSION NUMBER (IF KNOWN)**

Pension Number: \_\_\_\_\_

**3. SIGNATURE**

**DECLARATION AND AUTHORIZATION BY APPLICANT**

In consideration of my request for insurance coverage under the Service Income Security Insurance Plan (SISIP), I hereby authorize Public Works & Government Services Canada (PWGSC) to deduct the associated monthly premiums from my Canadian Forces Superannuation Act (CFSA) pension at such monthly rates as may from time to time be authorized pursuant to the SISIP Financial Services (SISIP FS) policy for said coverage with Manulife Financial. This authorization shall continue in effect until revoked in writing by me. A photocopy of this authorization shall be as valid as the original.

The information provided on this form is protected from unauthorized disclosure under *Canada's Privacy Act* and is available to you upon request.

\_\_\_\_\_  
Certificate Holder's Signature

\_\_\_\_\_  
Day Month Year

## Important Information for you Records



### Medical information Bureau

The following is a summary of the details about the release of personal information by the Medical Information Bureau. You acknowledge the receipt of this notice when you sign this application form.

Information regarding your insurability will be treated as confidential. Manulife Financial or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of the life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information on its file.

Upon receipt of a request form you, the Bureau will arrange disclosure of any information it may have on your file.

If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's information office is 330 University Avenue, Toronto, ON M5G 1R7. Telephone (416) 597-0590.

Manulife Financial or its reinsurers may also release information in its file to other insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

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For assistance in the completion of this application form, please contact the local SISIP FS insurance representative in your area or call 1-800-267-6681.

COLD LAKE	780-594-4562
BAGOTVILLE	418-677-3333
BORDEN/LONDON/NORTH BAY/TORONTO	705-424-2262
EDMONTON/WAINWRIGHT/CALGARY	780-973-3130
ESQUIMALT/COMOX/VANCOUVER/COLORADO SPRINGS	250-363-3301
GAGETOWN/MONCTON/PEI	506-357-3666
GREENWOOD	902-765-6714
HALIFAX/SHEARWATER	902-425-6926
KINGSTON	613-547-1172
NEWFOUNDLAND & LABRADOR	709-570-8480
OTTAWA	613-233-2177
PETAWAWA	613-687-0025
SHILO	204-765-7120
ST-JEAN/MONTREAL	450-357-9595
TRENTON	613-965-4823
VALCARTIER	418-844-0111
WINNIPEG/MOOSE JAW/REGINA	204-984-3222

**Please forward completed forms to:**

**SISIP Financial Services**  
NDHQ – 4210 Labelle Street  
Ottawa, ON K1A 0K2

[www.sisip.com](http://www.sisip.com)