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.

1. Member Information-Please Review Block A

SERVICE NUMBER (SN) | RANK | SURNAME | FIRST NAME | INITIALS | SEX ☐ M ☐ F

Mailing Address | Street | Apt | City | Birthdate: Day Month Year

Province | Postal Code | Unit/Base | C.F.Enrollment Date: Day Month Year

Home Telephone ( ) | Office Telephone ( )

Is your spouse a member or former member of the Canadian Forces?
☐ N/A ☐ No ☐ Yes
If yes, indicate Service Number

Are you leaving your home unit for a "theatre of operations"?

Location

Departure: Day Month Year

Expected Return: Day Month Year

This application is submitted to: (check as applicable)

- ☐ initiate coverage under: ☐ OGTI-Member ☐ OGTI-Spousal ☐ GOIP-Optional (Blocks 1, 5, 6 and 7 only)
- ☐ increase coverage under: ☐ OGTI-Member ☐ OGTI-Spousal
- ☐ decrease coverage under: ☐ OGTI-Member ☐ OGTI-Spousal
- ☐ transfer SIB to OGTI-Member (to a max amount of 50 x monthly salary rounded to the next higher multiple of 10,000)
- ☐ transfer Spousal-DL to OGTI-Spousal (to a maximum 2 units) ☐ Yes ☐ No
- ☐ transfer ☐ RTIP or ☐ CAR to OGTI
- ☐ terminate coverage under ☐ LTD ☐ SIB/DL ☐ OGTI-Member ☐ OGTI-Spousal ☐ GOIP-Optional
- ☐ change beneficiary
- ☐ change status to: ☐ Married ☐ Common Law ☐ Single ☐ Separated* ☐ Divorced ☐ Single Parent ☐ Non-Smoking
- ☐ request a refund of premium (see Refund, Block 10)
- ☐ obtain a certificate only

*For SIB only if applicable attach a Separation Declaration, (SISIP FS Form 4E)

2. Spousal Information (If applying for spousal coverage, or a transfer)

SERVICE NUMBER (SN) | SURNAME OF SPOUSE | FIRST NAME | INITIALS | SEX ☐ M ☐ F

Mailing Address: ☐ as above or

Mailing Address | Street | Apt | City | Birthdate: Day Month Year

Province | Postal Code | Date of Marriage (if applicable): Day Month Year

Maiden name (if applicable)

If applicable, attach a Declaration of Common-Law Relationship (SISIP FS Form 3E) or a Separation Declaration (SISIP FS Form 4E)

3. OPTIONAL GROUP TERM INSURANCE (OGTI)-MEMBER

Enter the amount of insurance desired on your life, in units of $10,000 to a maximum of $400,000. See **Block "B"** for premium rates.

(For SISIP FS use only)	Rate	Coverage in effect		Additional Coverage Requested		Total Coverage Requested	Monthly Premium
S 3		$	+	$	=	$ (MAX $400,000)	$

I hereby revoke any previous beneficiary designations which I may have made under the Group Policy No. 901102 and hereby designate the following beneficiary(ies), reserving to myself the right to revoke such designation. See Block A, Para 6 on front cover for further information.

	Name (in full) of Persons or Organizations	Relationship	Percentage
PRIMARY			100%
CONTINGENT			
CONTINGENT			

TRUSTEE | Address:

NOTE: The member (Block 3) and spouse (Block 4) may name any person(s) and/or organization(s) to be his/her beneficiary. If more than one Primary beneficiary 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 insufficient space, please complete Form SISIP FS 11E and staple it to this application. 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.

4. OPTIONAL GROUP TERM INSURANCE (OGTI)-SPOUSE

Enter the amount of insurance desired on your life, in units of $10,000 to a maximum of $400,000. See **Block "B"** for premium rates.

(For SISIP FS use only)	Rate	Coverage in effect		Additional Coverage Requested		Total Coverage Requested	Monthly Premium
S 4		$	+	$	=	$ (MAX $400,000)	$

I hereby revoke any previous beneficiary designations which I may have made under the Group Policy No. 901102 and hereby designate the following beneficiary(ies), reserving to myself the right to revoke such designation. See Block A, Para 6 on front cover for further information.

NOTE: The primary beneficiary for **OGTI - SPOUSAL** is always the applicant per block #1, unless otherwise stated in writing by the applicant. Otherwise, request and submit SISIP Form 11E - Designation / Change of Beneficiary.

	Name (in full) of Persons or Organizations	Relationship	Percentage
CONTINGENT			
CONTINGENT			

TRUSTEE | Address:

5. Medical History

PROTECTED "B" (when completed)

SN

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.

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

Question	Member Yes	Member No	Spouse Yes	Spouse No
5. Was there a 10% change in weight during the past year? If yes, please explain reason: .... Member:............ Spouse:	☐	☐	☐	☐
6. Have you ever applied for insurance that was declined, postponed, rated or modified in any way? If yes, please explain:	☐	☐	☐	☐
7. Have you ever claimed benefits for sickness, injury or impairment? If yes, please explain............	☐	☐	☐	☐
8. Have you ever lost days due to sickness, injury or impairment in the last two years? If yes, number of days lost: Member: .... Spouse:	☐	☐	☐	☐
9. Is future medical or surgical treatment for your active medical conditions being considered by your attending physician(s)? Please elaborate fully	☐	☐	☐	☐
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?............	☐	☐	☐	☐
11. Submitted to an EKG, blood tests, x-rays, or other diagnostic tests? If yes, which tests were performed?	☐	☐	☐	☐
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?............	☐	☐	☐	☐
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............	☐	☐	☐	☐
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?	☐	☐	☐	☐
15. Disorder of the eyes, ears, nose, or throat?	☐	☐	☐	☐
16. Sugar, albumin, blood or pus in urine, venereal disease (**indicate type**), stone or other disorder of kidney, ureters, bladder, prostate, or reproductive organs?	☐	☐	☐	☐
17. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, haemorrhoids, recurrent indigestion or other disorder of the oesophagus,stomach, intestine, liver, or gallbladder?	☐	☐	☐	☐
18. Diabetes, thyroid disorder including **toxic goitre** or other endocrine disorders?	☐	☐	☐	☐
19. Any disorder of the musculoskeletal system (e.g., arthritis (**indicate osteo or rheumatoid**), gout, neuritis, sciatica, etc. including the spine, back, or joints)?	☐	☐	☐	☐
20. Deformity, gait disorder, or amputation?............	☐	☐	☐	☐
21. Disorder of skin, lymph glands, cyst, tumour (**indicate benign or malignant**), or cancer	☐	☐	☐	☐
22. Allergies, anaemia or other disorder of the blood?	☐	☐	☐	☐
23. Any other illness, disease or condition not listed above?	☐	☐	☐	☐
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	☐	☐	☐	☐
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	☐	☐	☐	☐
26. Have you ever tested positive for HIV (Human Immunodeficiency Virus)?............	☐	☐	☐	☐
27. Have you been immunized against the hepatitis B virus? **If yes, please give year of immunization**:	☐	☐	☐	☐
Have you ever:				
28. Received treatment for alcohol and/or drug use?	☐	☐	☐	☐
29. Been charged with impaired driving, or been arrested due to the influence of alcohol and/or drugs?	☐	☐	☐	☐
30. Used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens, or any other drugs **not** obtained by prescription? If yes, give details:............	☐	☐	☐	☐
31. Used tobacco products? .... If yes, average daily consumption: Member:........ Spouse........ Total years of use Member........ Spouse........	☐	☐	☐	☐

6. Smoking / Non-Smoking Status

Have you smoked a cigarette in the last twelve months? CF MEMBER: YES ☐ NO ☐ SPOUSE: YES ☐ NO ☐

SN

7. Signature Block *(to be read and signed for all submissions including 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 SISIP Financial Services and Manulife Financial 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, 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);

c) and 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 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.

I hereby authorize a deduction from my pay account in payment of the SISIP FS 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* and is available to you upon request.

CF Member's Signature ______________ Day Month Year

Spouse's Signature ______________ Day Month Year

8. SISIP FS Representative who assisted in the completion of this form and/or Point of Contact who received this form

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

Name	Unit/Location	Telephone	Day	Month	Year
Representative		( )			
Point of Contact		( )			

9. Refund of premium (to be completed by member applying for a refund due to a change of status)

I hereby apply for a refund for the following reason:

NOTE

1. A separated or divorced Member, regardless of who has custody of the children, is still eligible for SIB/DL coverage and as such is not eligible for a refund.
2. If a change in status from smoker to non-smoker, give date of cessation of cigarette smoking for CF Member and/or Spouse. Effective 1 October 1997, non-smoker refunds are restricted to a maximum of three years from date of receipt of the request. Eligibility period begins after a Member and/or Spouse has been "cigarette smoke-free" for one year.

Stopped Smoking — CF Member: Day Month Year — Spouse: Day Month Year

☐ Refund approved
☐ Refund not approved

Day Month Year — SISIP FS

10. Approving Authority (to be completed only by SISIP FS or Manulife Financial)

The Member insurance coverage and the spousal insurance coverage is **APPROVED. ALLOTMENT WILL BE EFFECTIVE:** Day Month Year

The Member insurance coverage and the spousal insurance coverage is **NOT APPROVED**

Therefore, the current coverage in force is: ☐ LTD ☐ SIB OGTI (M) **$** OGTI (S) **$** ☐ GOIP (Basic) ☐ GOIP (Optional)

Day Month Year — SISIP FS **OR** Day Month Year — Group Underwriter, Manulife Financial

11. For SISIP FS Office USE

S185 ☐
Comp ☐

S2 ____ **S3** ____ **S4** ____ **L184** ____

ALLOTMENT ADVICE

Pay Allotment Code	Effective Date of Allotment	Premium	Voucher#	Date(D/M/Y)

Actioned By ______________ Day Month Year

BLOCK A.

1. Complete **ALL** sections of the SISIP Financial Services (SISIP FS) Form 1E for the coverage for **which you are applying.**

2. The **Medical History** (Block 5) is **NOT** required if:

   a) You wish to transfer your Survivor Income Benefit (SIB) to Optional Group Term Insurance (OGTI) coverage (maximum 50 x **monthly pay**) and $20,000 OGTI coverage to your spouse.
   b) You wish to transfer RTIP or Insurance for Release Members (IRM) coverage to OGTI.
   c) You wish to decrease coverage for OGTI-MEMBER and/or OGTI-SPOUSAL.
   d) You wish to change your beneficiary.
   e) You wish to change smoker/non-smoker status.
   f) You only wish to obtain a certificate

3. **Evidence of Insurability**
   Members applying for Member coverage other than in circumstances at paragraph two, **must complete the member's medical history (Block 5).** When applying for OGTI-SPOUSAL coverage, the spouse's medical history **(Block 5)** must be completed. Please note that a medical examination may be required for a non-serving spouse; if so the member and/or spouse will be provided with instructions by SISIP Financial Services (SISIP FS), or Manulife Financial.

NOTE: Applications are forwarded for processing to:
SISIP FS, 4210 Labelle Street, Ottawa, ON, K1A 0K2

4. When applicable, attach a SISIP FS Declaration of Common Law Relationship, Form 3E, and a SISIP FS Separation Declaration, Form 4E, to this form.

5. The maximum amount of OGTI permitted on any one life is $400,000. If a husband or wife are both members of the Canadian Forces, any one member cannot hold OGTI-MEMBER and SPOUSAL coverage totalling in excess of the $400,000 maximum per life.

6. The previous designation of a spouse as beneficiary by a member who became a **SISIP FS participant** while residing in the Province of Quebec may be irrevocable for the duration of the coverage, and generally a change of beneficiary cannot be made without the spouse's written permission. If applicable your spouse must complete and sign Form 11E, Designation/Change of Beneficiary.

BLOCK B.

PREMIUMS* PER AGE GROUP

MONTHLY	UNDER 25	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 & over
Non-smoker Rate / $10k	$0.70	$0.60	$0.65	$0.80	$1.05	$1.35	$2.00	$3.40	$4.30
Smoker Rate / $10k	$1.05	$0.95	$1.10	$1.25	$1.80	$3.00	$4.90	$5.40	$6.45

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

Summary of SISIP FS Plans

- Long Term Disability • For a total disability, 75% of pay on release less other relevant sources of income.
- Reserve Long Term Disability • For a total disability, 75% of pay on release for deemed, pre-selected or monthly income less other relevant sources of income.
- Spousal Disability Plan • A lump sum of $100,000 payable to a totally disabled insured person.
- Survivor Income Benefit • Ensures spouse receives 50% of monthly pay when combined with CFSA and Pension Act benefits.
- Optional Group Term Insurance • $10,000 to $400,000 Life insurance benefit on the life of member/spouse of Regular Force.
- Dependent Life Insurance • A lump sum of $10,000 on the life of each dependent child under the SISIP FS life plans.
- Reserve Term Insurance Plan • Similar to OGTI, for members and spouses of Reserve Force.
- Insurance for Released Members • OGTI/RTIP equivalent benefits for former CF members and their spouses.

Contact your area SISIP FS Representative or call 1-800 267-6681 for details.

In case of a conflict between this information and the insurance contracts, the terms of the contracts shall prevail.

SISIP FINANCIAL SERVICES OFFICES

NEWFOUNDLAND 709-570-8480
HALIFAX/SHEARWATER 902-425-6926
GREENWOOD 902-765-6714
GAGETOWN/MONCTON/PEI 506-357-3666
QUÉBEC/BAGOTVILLE 418-844-0111
OTTAWA/MONTRÉAL/ST-JEAN 613-233-2177
PETAWAWA 613-687-0025
KINGSTON 613-547-1172
BORDEN/LONDON/NORTH BAY/TORONTO/TRENTON 705-424-2262
WINNIPEG/SHILO/MOOSE JAW/COLD LAKE 204-774-1781
EDMONTON/WAINWRIGHT/CALGARY 780-973-3130
ESQUIMALT/COMOX/VANCOUVER/COLORADO SPRINGS 250-363-3301

1 800 267-6681 / www.sisip.com

Please forward completed application to:

SISIP FS
NDHQ
4210 Labelle Street
Ottawa, Ontario K1A 0K2