

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. How to apply

PROTECTED "B" (when completed)

- A. (1) When requesting **member** insurance coverage in blocks 9 and/or 10, blocks 2,3,5,7,8,9,10,12,13, must be completed.
 (2) When requesting **RES GOIP** Optional coverage, blocks 2,3,5, (for optional premium payment via EFT), 7 and 13 only must be completed.
- B. When requesting **Spousal** Life insurance coverage, blocks 2,3,4,5,7,8,11,12, and 13 must be completed.
- C. **Long Term Disability Coverage (Block 9):**
 (1) To select one of the two optional coverages at Block 9, the applicant must be a **Primary Reserve Force member**, or a member of the Reserve Force on Class "B" service for a period of more than 180 days. The member must attach a copy of the "Route Letter" or the "Employment Message" and a letter from his/her civilian employer indicating the applicant's annual salary, or, if self-employed, a letter from an at arm's length professional attesting to the applicant's annual income. Total annual salary or income must equal or exceed chosen deemed salary or income.

- D. **Premium required:**
 (1) If applying for LTD Optional Coverage only, the application must be accompanied by a cheque or money order for the total premium payable to "Manulife Financial" per block 12C.
 (2) If applying for Life Insurance Coverage alone or LTD Optional Coverage and Life Insurance Coverage, the applicant has the option of paying the monthly premium per Block 12A using the "Electronic Funds Transfer (EFT)" (complete Block 5), submitting a cheque or money order payable to "Manulife Financial" for the "Total Premium Required" per Block 12C or if you wish the monthly premium deducted from your CF Pension, complete the "CFSA Pension Deduction Authorization Card".
- E. Forward your completed application form to Manulife Financial, SISIP Services, P.O. Box 1030, Halifax, Nova Scotia B3J 2X5.
- F. The previous designation of a spouse as beneficiary by a member **who became a 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. Prepare and attach "Designation / Change of Beneficiary", Form 11E.
- For further details regarding the completion of this form or concerning the Reserve Force LTD Plan or the Reserve Term Insurance Plan please contact Manulife Financial at 1-800-565-0701 (in Halifax 453-4300), or the SISIP FS office at 1-800-267-6681 (in Ottawa 233-2177).

2. Member's Information

SERVICE NUMBER (SN)	RANK	SURNAME	FIRST NAME	INITIAL(S)	SEX <input type="checkbox"/> M <input type="checkbox"/> F
MAILING ADDRESS			CITY		Birthdate
STREET			APT		Day Month Year
PROVINCE			POSTAL CODE		Place of birth
HOME TELEPHONE ()			OFFICE TELEPHONE ()		Occupation
RESERVE UNIT					Maiden name (if applicable)
A. Reserve Service Class <input type="checkbox"/> A <input type="checkbox"/> B (180 days or less) <input type="checkbox"/> B (more than 180 days) <input type="checkbox"/> C					
B. Is your spouse a member or former member of the Canadian Forces? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes					If yes, indicate SN
C. Are you leaving your home unit for a "theatre of operations"? <input type="checkbox"/> Location					Departure Day Month Year
					Expected return Day Month Year

3. Commanding Officer's Certification

I hereby certify that the above named member is currently on: Class A Reserve Service Class B Reserve Service

Full name and Rank of Commanding Officer (please print) _____ Signature of Unit Commanding Officer (or designated authority) _____

Day Month Year

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

SURNAME OF SPOUSE	FIRST NAME	INITIALS	SEX <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate
MAILING ADDRESS <input type="checkbox"/> as above or			CITY	
STREET			APT	
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)

5. Pre-Authorized Debit (PAD) Agreement

- While the PAD is in effect, the Company will not give notice of the premiums falling due.
- All provisions of SISIP FS Policy #901102 relating to the payment or non-payment of premiums shall apply to the PAD.
- SISIP FS 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 FS, in writing. This notification must be received at least twenty (20) business days before the next debit. I may obtain a sample cancellation form, or more information on my right to cancel a PAD Agreement at my financial institution or by visiting www.cdnpay.ca.
- 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. To obtain more information on my recourse rights I may contact my financial institution or visit www.cdnpay.ca.
- If there are more than two failed transactions in any twelve month period, the Company may terminate the PAD and bill the undersigned for annual for annual payments in advance.

Please complete the following:

- | | |
|--|---|
| <p>1) Type of account
 Chequing <input type="checkbox"/> or Savings <input type="checkbox"/> AND Personal <input type="checkbox"/> or Business <input type="checkbox"/></p> <p>2) Day of the month to be withdrawn
 1st of the month <input type="checkbox"/> 15th of the month <input type="checkbox"/></p> <p>3) Depositor(s) name as shown on bank records (please print)
 _____</p> | <p>4) Signature(s) of depositor(s) as shown on bank records
 _____</p> <p>5) Date <input type="text"/> / <input type="text"/> / <input type="text"/>
 Day Month Year</p> <p>6) Attach VOID cheque OR complete form 15E.</p> |
|--|---|

6. Life Insurance Rates

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.

PROTECTED "B" (when completed)

7. 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.

- | | | | | | |
|---|---|---------------------------|--|--------|---|
| 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 weightkg/lb | | Member | Spouse |
| | Spouse:M/Ft.cm/in | Present weightkg/lb | | Yes No | Yes No |
| 5. Was there a 10% change in weight during the past year? If yes, please explain reason: | Member:.....
Spouse: | | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 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 not 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:..... |

8. 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"/>
--	------------	------------------------------	-----------------------------	---------	------------------------------	-----------------------------

PROTECTED "B" (when completed)

SN

9. Long Term Disability Coverage

NOTE: Members of the Primary Reserve on Class "A" or "B" reserve service (180 days or less), unless enrolling under one of the Optional Coverages, automatically acquire at no cost, the Basic Coverage for a deemed salary of \$2000, when authorized for service and entitled to pay.

OPTIONAL COVERAGE

Note: 1.To continue the response MUST be YES to one or both questions. 2.See Block 1.C. for proof of income requirement.

Are you a member of the Primary Reserve? YES NO Are you a member of the Reserve Force (>180days)? YES NO
Optional Salary \$3,000/monthCost: \$7.90
Optional Salary \$4,000/monthCost: \$15.80

\$
\$

10. Reserve Term Insurance Plan (RTIP) - Member

Enter amount of insurance desired on your life, in units of \$10,000 to a maximum of \$400,000. See block 6 for premium rates.

Transfer of and/or coverage in effect Additional coverage requested Total coverage requested # of Units Premium Rate
\$ + \$ = \$ ÷ \$10,000 = x =

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 1, Para F for further information

Table with columns: Full Name of persons or organizations, Relationship, Percentage. Includes PRIMARY, CONTINGENT, TRUSTEE rows.

\$

NOTE: The member (Block 10) and spouse (Block 11) 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.

11. Reserve Term Insurance Plan (RTIP) - Spousal

Enter amount of insurance desired on your life, in units of \$10,000 to a maximum of \$400,000. See block 6 for premium rates.

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

Note: The beneficiary for RTIP - Spousal is always the applicant per Block number two. If otherwise, request and submit Form SISIP FS 11E - Designation / Change of Beneficiary.

\$

12. Summary of Premium Required (see block 1):

- A. Total Monthly Premium (Add amounts in right-hand column):
B. Number of months:
C. Total Premium Required (12A x 12B)

\$
x 12
\$

13. 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 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) 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. It is further acknowledged that a statement regarding the release of personal information by The Medical Information Bureau has been received.

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 Spouse's Signature Day Month Year

14. 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 SISIP FS

Name Unit/Location Telephone Day Month Year

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

The member insurance coverage and the spousal insurance coverage is APPROVED effective:

The member insurance coverage and the spousal insurance coverage is NOT APPROVED. Day Month Year SERVICE NUMBER

Therefore, the current Res LTD Res LTD (optional) \$ RTIP (M) \$ RTIP (S) \$ Res GOIP (Basic) Res GOIP (Optional)

SISIP FS Day Month Year Group Underwriter, Manulife Financial Day Month Year



Pre-Authorized Payment Form

for the Reserve Term Insurance Plan (RTIP)
Group Policy No. 901102

1. MEMBER INFORMATION

<input type="text"/>	<input type="text"/>	<input type="text"/>		
Service Number (SN)	Rank	Surname	First Name	Initials
<input type="text"/>			<input type="text"/>	
Mailing Address			Home Phone #	
<input type="text"/>			<input type="text"/>	
PO Box, Rural Route, etc.			(circle) work/cell phone/pager #	
<input type="text"/>	<input type="text"/>	<input type="text"/>		
City	Prov.	Postal Code		

2. FINANCIAL INSTITUTION'S INFORMATION

<input type="text"/>		
Financial Institution Name		
<input type="text"/>		
Financial Institution Address		
<input type="text"/>	<input type="text"/>	<input type="text"/>
City	Prov.	Postal Code

3. ACCOUNT INFORMATION

<input type="text"/>	<input type="text"/>	<input type="text"/>
Branch	Institution	Account Number

4. SIGNATURE

Declaration and Authorization by Applicant

I authorize the pay office/DAPPP to provide SISIP Financial Services and Manulife Financial with my personal banking information only for the purpose of automatically withdrawing premiums for my RTIP policy(ies) from the above on a monthly basis;

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

Day	Month	Year

Please attach this completed form to your Reserve Term Insurance Plan (RTIP) application and/or mail to:

SISIP Financial Services
National Defence Headquarters
234 Laurier Avenue West
Ottawa, ON K1A 0K2

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.

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:

Manulife Financial
SISIP Financial Services
2727 Joseph Howe Drive
PO Box 1030
Halifax, NS B3J 2X5

To follow up on this application, please contact Manulife Financial at 1-800-565-0701