

5. 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 weight.....kg/lb		Member	Spouse
	Spouse:M/Ft.cm/in	Present weight.....kg/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 the 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:.....

6. 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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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 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

Representative	<input type="text"/>	<input type="text"/>	<input type="text"/>
Point of Contact	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Unit/Location	Telephone	Day Month Year

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**
- 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.
 - 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.

CF Member Spouse Refund approved Refund not approved SISIP FS

Stopped Smoking Day Month Year Day Month Year Day Month Year

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)

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

11. For SISIP FS Office USE

S185 S2 S3 S4 L184
 Comp

ALLOTMENT ADVICE

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

Actioned By Day Month Year

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

2. The **Medical History** (Block 6) is **NOT** required if:

- a) You wish to transfer your SIB to OGTI coverage (maximum 50 x **monthly pay**) and \$20,000 OGTI coverage to your spouse.
- b) You wish to transfer RTIP or CAR 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 6)**. When applying for OGTI-SPOUSAL coverage, the spouse's medical history (**Block 6**) 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:**
- (1) No evidence of insurability is required when transferring the \$20,000 SIB/DL to OGTI-Spousal.
 - (2) Applications are forwarded for processing to: SISIP Financial Services at NDHQ, 234 Laurier Ave. West, Ottawa, Ontario, 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 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".

Summary of SISIP FS Plans

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

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.

SISIP FINANCIAL SERVICES OFFICES

- HALIFAX/SHEARWATER/GREENWOOD/NEWFOUNDLAND(902) 425-6926
- NEW BRUNSWICK/PRINCE EDWARD ISLAND(506) 357-3666
- QUÉBEC/BAGOTVILLE(418) 844-0111
- OTTAWA/MONTRÉAL/ST-JEAN(613) 233-2177
- PETAWAWA/KINGSTON(613) 687-0025
- BORDEN/LONDON/NORTH BAY/TORONTO/TRENTON(705) 424-2262
- MANITOBA/SASKATCHEWAN(204) 889-4656
- ALBERTA/COLD LAKE(780) 973-3130
- BRITISH COLUMBIA(250) 360-0006

1 800 267-6681