

Insurance for Released Members (IRM)

(term life insurance to age 75)

1. INSURANCE NEEDS ANALYSIS (INA)

Purchasing life insurance is a crucial component of your overall financial security plan. SISIP Financial requires each applicant to complete an **Insurance Needs Analysis (INA)** at the time of application. Completing an INA will help ensure you understand your current life insurance needs and make an informed decision regarding your coverage. To complete an INA, contact SISIP Financial.

2. PURPOSE OF THIS APPLICATION (CHECK ALL THAT APPLY):

nitiate coverage under: IRM-MIRM-S	Increase coverage under:	Decrease coverage under:
3. ADMINISTRATIVE INFORMATION:		

1. Is/was your spouse or former spouse a CAF member?

N/A

Yes No

If "yes", indicate name and Service Number of person.

and SN:

Note: Maximum total insurance coverage on any one person, through individual and spousal coverage, cannot exceed \$1,200,000.

4. IMPORTANT NOTES

- To transfer eligible coverage to IRM at time of release, a member MUST APPLY within <u>60 days of their release date</u>. The Health Questionnaire, Block 12, is NOT required.
 To initiate or increase IRM coverage, the member or his spouse must be less than 66 years of age. The Health Questionnaire, Block 12, must be completed.
- Please note that a medical examination may be required. If required a medical form will be sent with the necessary instructions.
- 3. If the amount eligible for transfer exceeds **\$1,200,000**, the balance may be converted to an individual policy with Manulife.

5. MEMBER INFORMATION

Service Number (SN)			CFOne #			Rank			
Date of Birth (dd-mm-yyyy)		Surname			First Name			Initials	M _ F _
Date of Release (DOR) (dd-mm-yyyy)			F 1	Primary/Day Telephone			Secondary/ Evening Telep	ohone	
Apt.	Civic #	Street	t				City		
Province		Postal Code		Email Address					

6. SPOUSAL INFORMATION (IF APPLYING FOR SPOUSAL COVERAGE, INCREASE, DECREASE OR A TRANSFER)

Service Number (SN)		CFOne #			Rank
Surname	First Name		Initials	Maiden Name (if applicable)	M F
Mailing address same as above: Only enter mailing address if different from member:		Date of Birtl (dd-mm-yyy		Date of Marriage (if applicable) (dd-mm-y	луу)
Apt. Civic #	Street			City	
Province	Postal Code		Email Address		

7. PREMIUMS* PER AGE GROUP

MONTHLY	Under 25	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74
Non-Smoker Rate / \$10,000	\$0.70	\$0.60	\$0.65	\$0.80	\$1.05	\$1.35	\$2.00	\$3.40	\$6.00	\$11.00	\$23.17
	\$1.05	\$0.95	\$1.10	\$1.25	\$1.80	\$3.00	\$5.15	\$8.50	\$15.00	\$25.00	\$48.47

8. SMOKING/NON-SMOKING STATUS

a) Have you used tobacco or a tobacco product in the last twelve (12) months?

b) Date you last used tobacco or a tobacco product?

CAF Mem	ber (M):	YES 🗌 NO	
dd	mm	уууу	

Spouse (S	5): YES	NO
dd	mm	уууу



														SN:					
9. N	IEMBER C	OVERAG	GE If Total Coverage Re	quested	is more	e than \$	250,000 ,	see Bloc	k 1 INSU	RANCEN	IEEDS ANALYSI	I S on	Page 1						
Lif	e insurance i	s availabl	e in increments of \$10	0,000 to	o a ma	ximum	n of \$1,2	200,000											
\$		+	\$						÷ \$10,0	00 =		×	:		7 =				
	overage in Effec	ct	(+/-) Change in Covera	age	Tota	l Covera	age Requ		,		# of Units		Mo	nthly Rate			Monthly	Premiun	n
			f a spouse by a member w																change
Note 2:	The member (E	Block 5) and	e's written permission. If a spouse (Block 6) may nan	me any pe	erson(s)) and/or	organizat	tion(s) to	be their b	eneficiary	. If more than o	ne pi	rimary be	neficiary is t	o be n	amed, ticl	< PRIMAR	Y in each	
and atta	ach it to this app	olication. If r	ed percentage for each be ninor children are include of death of the primary be	ed, the da	te of bi	rth of th	e childrer	h and the	name and	l address	of the Trustee/	Tutor							
As the	certificate holde	r, I hereby ı	evoke any previous bene	eficiary de	· /			0		,			and here	eby designa	te the	following	beneficia	ary(ies).	
	ficiary design	lation is rev	ocable unless stated othe Name (in full) o		ons oi	r Orga	nizatio	ns		Re	lationship			Date of B	irth		Pe	ercenta	ge
🗌 PRI	MARY											6	dd	mm	уууу	/			
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	NTINGENT MARY												dd	mm	<i>yyy</i> y	/			
							Addr	ress and		<u> </u>									
TRUS	TEE/TUTOR						telep	hone #:											
10.	SPOUSAL	COVER	AGE If Total Coverage	Requeste	ed is m	ore thar	n \$250,00	00, see B	lock 1 INS	URANCI	E NEEDS ANAL	YSIS	on Page	1					
Lif	e insurance i	s availabl	e in increments of \$10	0,000 to	o a ma	ximum	n of \$1,2	200,000											
\$		+	\$	=					÷ \$10,0	00 =		×	:		=				
Co	overage in Effec	ct	(+/-) Change in Covera	age	Tota	l Covera	age Requ	ested			# of Units		Mo	nthly Rate			Monthly	Premiun	n
			r IRM-SPOUSAL is always t I, the PRIMARY box is to be																
enter th	e desired perce	ntage for ea	ach beneficiary in the last of cluded, the date of birth o	column. T	The tota	l must e	qual 1009	%. If insut	fficient spa	ce, please	e complete the <u>E</u>	Desig	nation/Ch	ange of Ber	neficiar	۲ form (1	IE) and at	tach it to	this
			neficiary(ies). The total for / previous beneficiary des		· ·						o. 901102 and he	ereby	/ designat	e the follow	ing bei	neficiary(ie	es).	-	-
This be	neficiary design	ation is rev	ocable unless stated othe	erwise.															
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2002	SISIP Financia
age 2	Protected "B"

											SN:					
												[Mem	ber (M)	Spou	ise (S)
													YES	NO	YES	NO
						luding AIDS or AI to the AIDS virus), or any genera	lized enlarger	ment					
		t five years, have y or condition, i				ealth care practi ady disclosed?	tioner for a	iny								
4. Do you ha	ave any heal	th conditions fo	r which furtl	her treatm	ent, exam	ination, diagnost	ic test(s) or	surgery has b	een advised or	contemplated	1?					
5. Are you ta	aking any pro	escribed medica	tions? If "Y	es", list cu	rrent me	dications and d	osage in tl	ne details sect	tion below.							
6. Are you a	ware of any	symptoms or co	omplaints re	garding yo	ur health	2										
7. Have you	used in any	form: cannabis,	tobacco or	nicotine pr	oducts? I	f you answer "Ye	es", please	provide detai	ils immediatel	y below:						
Member (M)	F	Product #1	Pro	duct #2		Product #3	Spous	e (S)	Product	#1	Pro	duct #2		Pr	oduct #	3
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Name:			Те	lephone: _			Name:				Te	lephone:				
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14. Please co	mplete the f	ollowing inform	ation about	your last n	nedical vis	iit:										
Patient	Date of	Last Visit yyyy	Rea	son for Vis	it			Nam	e and address	of Physician	or cli	nic				
Member (M)																
Spouse (S)																
						I										
Note: If you	ı answere		y questio	n from 1		ve please pro , signature and					e a se	parate	sheet	providi	ng the	
Question																

Question Number (1 to 6)	M or S	Details, Diagnosis, Duration, Results	Dat mm	e Treated <i>yyyy</i>	Treatment & Results	Name and address of Physician or clinic

Page 3



13. PRE-AUTHORIZED DEBIT	(PAD) AGREEMENT	(if applicable, see Block 11)

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:

Account number (7-12 digits): _

. г 7 [Business

nonth

4 Depositor(s)' signature(s) as shown on hank records:

dd	mm	уууу
dd	mm	уууу

5. Bank number (3 digits): Branch number (up to 5 digits):

> ; or, attach a VOID cheque or bank produced PAD form.

14. 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.

Note 2: For further details regarding the completion of this form or concerning the Insurance for Released Members option please contact SISIP Life Insurance - Manulife at 1-800-565-0701 (in Halifax at 902-453-4300), or SISIP Financial at 1-800-267-6681.

Note 3: Forward your completed application form to: SISIP Life Insurance – Manulife, P.O. Box 1030, 2727 Joseph Howe Drive, Halifax, NS B3J 2X5.

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.

	Member's ne Printed						CAF Membe Signature:	r's					dd		mm	уууу		
												cted regarding o			cial			
Spouse's Name Printed:		:											dd		mm	уууу		
		Spouse's	Spouse's signature is only required to initiate or increase their coverage.							I consent to being notified or contacted regarding other SISIP Financial products or services: Initial:YES orNO								
15	. SISIP FI	NANCI	AL AD	VISOR	who assis	ted in the com	pletion of and/	or review	ved this forr	n								
(Once this	area is c	omplet	ed, this	form is to	be sent imm	ediately to SIS	SIP Finar	icial.									
[Name		B						nch				Was an Insurance Needs Analysis (INA) completed (initial):					
	Signature							dd	dd mm yyyy									
16	. APPRO	VING A	UTHO	RITY (t	o be comp	leted by SISIP	Financial or Ma	nulife)										
	The Merrinsurance		e is:	Cancell	ed 🗌	Postponed	year(s)	Denied [proved fective Date	dd	mm	ууу	у		
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1. Type of account: Chequing or Savings AND Personal or B
2. Day of the month to be withdrawn: 1^{st} of the month 15^{th} of the r
3. Depositor(s)' name(s) as shown on bank records printed:

SN: