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

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 M ☐ F ☐

MAILING ADDRESS STREET APT | CITY | Birthdate Day Month Year

PROVINCE | POSTAL CODE | RESERVE UNIT | Place of birth

HOME TELEPHONE ( ) | OFFICE TELEPHONE ( ) | Occupation

Maiden name (if applicable)

A. Reserve Service Class ☐ A ☐ B (180 days or less) ☐ B (more than 180 days) ☐ C

B. **Is your spouse a member or former member of the Canadian Forces?** ☐ N/A ☐ No ☐ Yes **If yes, indicate SN**

C. Are you leaving your home unit for a **"theatre of operations"?** 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 ☐ M ☐ F | Birthdate Day Month Year

MAILING ADDRESS ☐ as above or STREET APT | CITY | Place of birth

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:

1) Type of account
Chequing ☐ or Savings ☐ **AND** Personal ☐ or Business ☐

2) Day of the month to be withdrawn
1st of the month ☐ 15th of the month ☐

3) Depositor(s) name as shown on bank records (please print)

4) Signature(s) of depositor(s) as shown on bank records

5) Date Day Month Year

6) Attach VOID cheque **OR** complete form **15E**.

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.

SN

7. Medical History

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 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:

Question	Member Yes	Member No	Spouse Yes	Spouse No
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

Question	Member Yes	Member No	Spouse Yes	Spouse No
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:

Question	Member Yes	Member No	Spouse Yes	Spouse No
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........

8. Smoking / Non-Smoking Status

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

SN

9. Long Term Disability Coverage

NOTE: Members of the Primary Reserve on Class "A" or "B" reserve service (180 days or less), unless enroling 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. Members of the Reserve Force on Class "B" (more than 180 days) acquire the coverage based on their rate of pay, also at no cost.

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/month ....Cost: $7.90 $

☐ Optional Salary $4,000/month ....Cost: $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

	Full Name of persons or organizations	Relationship	Percentage
PRIMARY			100%
CONTINGENT			
CONTINGENT			
TRUSTEE		Address:	

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. If insufficient space, please complete Form SISIP FS 11E and staple 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 a case of death of the Primary 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		Additionnal 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: .... x 12

C. Total Premium Required (12A x 12B) .... $

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: Day Month Year   SERVICE NUMBER

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

Therefore, the current coverage in force is: 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

Service Number (SN) | Rank | Surname | First Name | Initials

Mailing Address

Home Phone # (   )

PO Box, Rural Route, etc.

(circle) work/cell phone/pager # (   )

City | Prov. | Postal Code

2. FINANCIAL INSTITUTION'S INFORMATION

Financial Institution Name

Financial Institution Address

City | Prov. | Postal Code

3. ACCOUNT INFORMATION

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.

Member's Signature

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
4210 Labelle Street
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