

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				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"?		Departure		Expected return	
Location		Day Month Year		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
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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			Place of birth	
STREET		APT		CITY
PROVINCE		POSTAL CODE		Date of Marriage (if applicable)
				Day Month Year
If applicable, attach a Declaration of Common-Law Relationship (SISIP FS Form 3E) or a Separation Declaration (SISIP FS Form 4E)				Maiden name (if applicable)

5. Request for Electronic Funds Transfer (EFT)

The Manulife Financial, as the insurer of SISIP Group Policy #901102, is hereby requested and authorized to use the EFT to automatically withdraw monthly on the account described on the specimen cheque attached for the purpose of paying premiums. This authorization and request shall also apply to any other account in any financial institution subsequently named by me with the provision of a specimen cheque on such new account.

It is understood and agreed that:

(1) While the EFT is in effect, the Company will not give notice of the premiums falling due.
 (2) The EFT may be terminated on written notice by the bank depositor to the Company. If there are more than two failed transactions in any twelve-month period, the Company may terminate the EFT and bill the undersigned for annual payments in advance.
 (3) All provisions of SISIP Group Policy #901102 relating to the payment or non-payment of premiums shall apply to the EFT.

Please complete the following:

(1) Date of Month to be deposited
 1st of the month 15th of the month

(2) Signature(s) of Depositor(s) as shown in Bank records

(3) Signature of Group Certificate holder if other than in (2)

(4) Date

	Day	Month	Year
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NOTE: Please attach a specimen cheque MICR encoded for your account

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 weight.....kg/lb | Member | | |
| | Spouse:M/Ft.cm/in | Present weight.....kg/lb | Yes No | Spouse | |
| 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"/> | <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"/>
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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. 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/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 \$ [] ÷ \$10,000 = # of Units [] x Premium Rate [] = 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 \$ [] + Additional coverage requested \$ [] = Total coverage requested \$ [] ÷ \$10,000 = # of Units [] x Monthly Premium Rate [] = 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 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

IMPORTANT INFORMATION
(Please retain this page for your records)

Medical Information Bureau

The following is a summary of 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. The Manulife Financial or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau a non-profit membership organization of 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 a 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 from you, the Bureau will arrange disclosure of any information it may have on your file.

If you question the accuracy of 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.

The Manulife Financial or its reinsurers may also release information on its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

For assistance in the completion of this application, please contact a local SISIP FS insurance representative in your area, or call 1-800-267-6681.

Local SISIP FS numbers:

Halifax/Shearwater/Greenwood/Newfoundland:	(902) 425-6926
New Brunswick/Prince Edward Island:	(506) 357-3666
Quebec/Bagotville:	(418) 844-0111
Ottawa/Montreal/St-Jean:	(613) 233-2177
Petawawa/Kingston:	(613) 687-0025
Borden/London/North Bay/Toronto/Trenton:	(705) 424-2262
Manitoba/Saskatchewan:	(204) 984-3222
Alberta:	(780) 973-3130
British Columbia:	(250) 360-0006

Application pages 1 to 3 once completed, can be forwarded to:

**Manulife Financial
SISIP Services
PO Box 1030
7 Maritime Place
Halifax, NS B3J 2X5**

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