CATCA SAFE LANDING

CRITICAL ILLNESS INSURANCE

CHUBB POLICY: CI10334601

Member Information (Please print clearly in ink, sign and date the form.)

Last name_____ First name_____ Initial_____

Home address_____

City_____ Prov._____ Postal Code_____ PRI #_____

Telephone_____ Email_____ Birth date_____
(YYYY/MM/DD)

Sex: Male ☐ Female ☐ Language: English ☐ French ☐ Smoking status: Smoker ☐ Non-smoker ☐

Legal spouse/common-law partner (if applicable)

Last name_____ First name_____ Initial_____

Sex: Male ☐ Female ☐ Birth date_____
(YYYY/MM/DD)

Health Questionnaire

Please check Yes or No

	Member		Spouse	
	Yes	No	Yes	No
1. Have you ever sought advice or received treatment for, or had any known indication of:				
a. Stroke (including transient ischemic attack), heart attack, coronary artery disease, severe valvular heart disease e.g. aortic stenosis, or any type of cardiac surgery?				
b. Cancer, tumour or malignancy?				
c. Advanced ophthalmic disease?				
d. Multiple sclerosis or paralysis?				
e. Any chronic or progressive disease or disorder of the kidney, lung, liver, pancreas or bone marrow that may lead to the failure of the organ or that may require transplantation?				
f. AIDS, HIV, chronic or unexplained infections?				
2. Within the last five years have you ever had, been diagnosed with or had any known indication of a medical problem with respect to the following:				
a. Untreated or uncontrolled high blood pressure, angina, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of, a cardiac event?				
b. Diabetes, digestive or intestinal disorder, excluding functional disorders e.g. Irritable Bowel Syndrome?				
c. Hospitalized due to a medical problem with respect to severe respiratory disorder?				
d. Used habit forming drugs, or received treatment or medical advice due to the use of drugs or alcohol?				
3. Have you ever been declined for life insurance or offered coverage only at higher than standard rates?				
4. Does your height and weight fall outside the chart noted below?				

Males					
Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4’ 8”	95	145	5’ 8”	132	207
4’ 9”	98	150	5’ 9”	137	213
4’ 10”	100	155	5’ 10”	141	219
4’ 11”	103	160	5’ 11”	145	225
5’ 0”	105	165	6’ 0”	150	233
5’ 1”	108	170	6’ 1”	155	241
5’ 2”	111	175	6’ 2”	160	249
5’ 3”	114	180	6’ 3”	165	257
5’ 4”	118	185	6’ 4”	170	265
5’ 5”	121	190	6’ 5”	175	272
5’ 6”	124	195	6’ 6”	180	279
5’ 7”	128	201	6’ 7”	185	285

Females					
Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4’ 8”	86	145	5’ 8”	119	207
4’ 9”	88	150	5’ 9”	123	213
4’ 10”	90	155	5’ 10”	127	219
4’ 11”	93	160	5’ 11”	131	225
5’ 0”	95	165	6’ 0”	135	233
5’ 1”	97	170	6’ 1”	140	241
5’ 2”	100	175	6’ 2”	144	249
5’ 3”	103	180	6’ 3”	149	257
5’ 4”	106	185	6’ 4”	153	265
5’ 5”	109	190	6’ 5”	158	272
5’ 6”	112	195	6’ 6”	162	279
5’ 7”	115	201	6’ 7”	167	285

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	Member		Spouse	
	Yes	No	Yes	No
5. Have you ever sought advice or received treatment for, or had any known indication of:				
a. Advanced loss of hearing?				
b. Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorders?				
c. Any psychiatric disorder, mental deterioration or loss of intellectual ability?				
d. Gout, arthritis, scleroderma, muscular dystrophy, ataxia, systemic lupus erythematosus, transverse myelitis, myasthenia gravis, post-polio syndrome, sarcoidosis or cystic fibrosis?				
e. Amputation due to disease?				
f. AIDS, HIV, chronic or unexplained infections?				
6. Do you currently:				
a. Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, oxygen, motorized cart or stair lift?				
b. Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence?				
c. Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?				

Optional Benefit Amount Selection (Indicate the total amount of coverage required)

Member coverage $_____

Spousal coverage $_____

Maximum available coverage for employee and spouse is $150,000 each and must be in units of $10,000.

	Male		Female	
Age	non-smoker	smoker	non-smoker	smoker
20–24	$2.60	$3.45	$2.90	$3.90
25–29	$2.60	$3.45	$2.90	$3.90
30–34	$3.80	$5.60	$4.55	$6.35
35–39	$5.30	$8.95	$6.90	$10.15
40–44	$8.30	$15.30	$10.55	$16.70
45–49	$13.65	$26.55	$15.45	$26.35
50–54	$23.05	$46.30	$22.10	$40.70
55–59	$43.05	$84.85	$34.65	$65.55
60–64	$79.30	$146.45	$55.90	$100.70

Beneficiary Designation

Please note: In the province of Quebec, if you have designated your married or civil union spouse as beneficiary, the designation will be considered irrevocable unless you check the box entitled "Revocable".

I hereby make the beneficiary designated below:

☐ Revocable, I may elect to change this beneficiary designation at any time.

Last name_____ First name_____

Birth date_____ Relationship to member_____

(YYYY/MM/DD)

Privacy

Protecting your personal information: Coughlin & Associates Ltd. ("Coughlin") recognizes and respects every individual's right to privacy. We are committed to keeping personal information private, confidential, accurate and secure. When personal information is provided to us, we establish a confidential file that is kept in our office, or the office of an organization authorized by us. Personal information is kept in a secure environment. We limit access to personal information in your file to Coughlin staff or persons authorized by Coughlin who require access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to administer the plan. You may exercise certain rights of access to the personal information in your file, and where appropriate, to have inaccurate information corrected by sending a written request to Coughlin. For information on our Privacy Policy, visit our website at www.coughlin.ca, or send a written request to our Privacy Officer by mail or by email at privacy@coughlin.ca.

Authorization

I authorize Coughlin & Associates Ltd. ("Coughlin") to collect, use, maintain and disclose my personal information with the following persons, organizations or parties: health care providers; companies affiliated with Coughlin; financial institutions; government agencies; insurance companies and their reinsurers and/or service providers; employers or former employers; my local union; plan trustees and auditors for the purposes of plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility (as applicable). When providing personal information for my spouse and/or dependants, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this section is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Member's signature (mandatory) Date

(YYYY/MM/DD)

Spouse signature (for spouse's coverage) Date

(YYYY/MM/DD)

INFORMATION ABOUT YOUR INSURABILITY AND YOUR DEPENDANTS' INSURABILITY WILL BE TREATED AS CONFIDENTIAL.