CATCA PLAN+

CATCA Canadian Air Traffic Control Association

OPTIONAL GROUP LIFE INSURANCE

CANADA LIFE POLICY: 138020 CHUBB POLICY: OE10373701

Application for optional group term life insurance

Member Information

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) Smoking status: Smoker ☐ Non-smoker ☐

☐ CHILDREN'S COVERAGE (IF APPLICABLE)

I apply for coverage on my child(ren) in the amount of $5,000 for each child and attest that he/she is in good health.

Child's last name ________________ First name________________ Birthdate____________ (YYYY/MM/DD)

Child's last name ________________ First name________________ Birthdate____________ (YYYY/MM/DD)

Total Coverage Requested

(Indicate the total life insurance coverage required in the space provided. Coverage must be in units of $10,000 to a maximum of $500,000)

☐ Member coverage $____________ ☐ Spousal coverage $____________

Member's Beneficiary Designation

Last name ____________________

First name____________________

Relationship to member________________

The beneficiary for the spouse/child coverage will be the member, if living, otherwise the member's estate. Where the Civil Code of Quebec applies, any designation of a legal spouse (married or civil union) as beneficiary is irrevocable unless you make the designation revocable by checking the box marked "revocable".

I hereby make the designation ☐ Revocable

Optional Group Term Life Insurance Coverage

The following are the monthly premiums for each $10,000 unit of coverage. The maximum coverage available is $500,000 for members and $500,000 for spouses, including the accidental death and dismemberment coverage at no extra cost. Premiums are based on your age, sex and smoking habits. An additional monthly premium of $0.65 covers all of your eligible dependant's children. Each child will be insured for $5,000 of life insurance.

	Male		Female	
Age	non-smoker	smoker	non-smoker	smoker
under age 34	$0.50	$0.71	$0.43	$0.50
35–39	$0.50	$0.71	$0.43	$0.50
40–44	$0.85	$1.28	$0.71	$0.85
45–49	$1.56	$2.13	$1.21	$1.42
50–54	$2.83	$4.33	$1.92	$3.12
55–59	$4.33	$6.31	$3.05	$4.75
60–64	$6.31	$11.05	$4.11	$6.17
65–69	$8.72	$14.53	$5.46	$8.01

*** Rates will increase to the next age category on February 1st following the attainment of a higher age category.**

Example: *The monthly premium for a 38-year-old female non-smoker requiring $100,000 of coverage (10 x $10,000) would be $4.30 (10 x $0.43). Premiums for a 38-year-old male non-smoker requiring the same amount of coverage would be $5.00 (10 x $0.50).*

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Medical and Lifestyle Questionnaire

Member's height____________ ☐ ft/in. ☐ cm   Member's weight____________ ☐ lbs. ☐ kg

Spouse's height____________ ☐ ft/in. ☐ cm   Spouse's weight____________ ☐ lbs. ☐ kg

	Member		Spouse	
	Yes	No	Yes	No
1. Have you smoked cigarettes in the past 12 months?				
2. Do you have any knowledge of any condition now existing that might require hospitalization or future surgical or psychiatric treatment?				
3. Have you ever applied for life or health insurance that has been declined, postponed or modified in any way?				
4. Do you have any reason to believe that you are not now in first-class health and free from any symptoms of disease?				
5. Do you currently participate in any hazardous activity such as scuba diving, piloting aircraft, auto racing, sky diving, hang gliding, motorcycle racing, etc? If yes, please specify:				
6. During the past two years, have you received medical or surgical attention because of illness or injury?				
7. During the past five years, have you had X-rays, electrocardiograms, blood or other special tests for other than regular medical check-ups?				
8. During the past five years, have you had heart trouble, pain or tightness in the chest, high or low blood pressure, any blood disorder, any intestinal disorders, any thyroid disorder, AIDS or other disorder of the immune system or test results exposure to the AIDS virus (HIV), asthma, tuberculosis or any lung disorder, cancer tumors, hepatitis, any liver disorder, any kidney disorder or blood, albumin or sugar in your urine, rheumatic fever, paralysis or disorder of the muscles or bones, including joints, spine and skin?				

If "yes" to any question, please provide details in the space below including the following: details or name of condition; treatment and results (recovery or remaining effects); names and addresses of doctors and hospitals; and date of treatment.

Member: ____

____

Spouse:____

____

Authorization

I confirm that I am an actively employed member of the Canadian Air Traffic Control Association (CATCA), or spouse of same, and hereby request the insurance offered by CATCA. **I AUTHORIZE:** Coughlin the use of my personal information for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; companies affiliated with Coughlin; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. 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 Authorizations & Questionnaire section is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

The foregoing information will be used by Canada Life to determine your insurability and to provide benefits under this plan.

I AUTHORIZE: Canada Life, any health care provider, my plan administrator, other insurance companies, the Medical Information Bureau, other organizations, or benefit service providers working with Canada Life to exchange information, when necessary, to determine my insurability and to administer the group benefit plan: Canada Life to perform tests, examinations, blood profiles and urinalysis tests as may be required to determine my insurability in connection with this application.

I CERTIFY OR CONFIRM THAT: I am an actively employed member of the Canadian Air Traffic Control Association, or spouse of same, on the date this application is signed; I have read and agree with the Important Notice describing the procedures of the Medical Information Bureau; I have retained a copy of this application; If applying for coverage for dependants, I am authorized to act on their behalf; A photocopy or an electronic copy of this authorization is as valid as the original. The statements and answers on this form will be used to determine your insurability and to provide benefits under this plan. Any changes in the accuracy of any of the statements and answers on the form between the date this form is signed and the date Canada Life makes a decision must be reported to Canada Life. I understand that if I fail to do so, any coverage granted may be void. I declare that to the best of my knowledge, all of the above answers to the questions are complete and true. I understand that if any answer is incomplete or false, any coverage granted may be void. I understand that I may be refused coverage for all or part of any benefit if, in the opinion of Great-West Life, I am not insurable for all or part of that benefit.

For Quebec applicants: I request that all communication and documents be in English. Je demande à ce que toutes les communications et tous les documents soient en anglais.

Member's signature (Mandatory)   Date (YYYY/MM/DD)

Spouse signature (For spouse's coverage)   Date (YYYY/MM/DD)

NOTICE ABOUT THE MEDICAL INFORMATION BUREAU

Your personal information will be treated as confidential. Canada Life or its reinsurers may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance, or submit a claim for benefits to such a company, the Bureau will, upon request, supply the company with the information it may have.

Canada Life or its reinsurers may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The company will not, however, reveal to another company or to the Bureau the action taken on the basis of your current request for insurance. If you wish to see the information in your Bureau file, or have it corrected, contact the Medical Information Bureau office at 330 University Avenue, Toronto, Ontario, M5G 1R7, telephone 416-597-0590.

CANADA LIFE: Protecting your personal information

Canada Life recognizes and respects every individual's right to privacy. When you apply for coverage, it establishes a confidential file that is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. It limits access to information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access and to persons authorized by law. It uses the information to provide you with financial services and to administer the group benefit plan.

COUGHLIN & ASSOCIATES LTD.: Protecting your personal information

The administrator of your group benefits plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.