Manulife Financial Policy No. GL17700 | canada life Policy No. 138473G0A

Public Service Alliance of Canada
Alliance de la Fonction publique du Canada

Enhanced Coverage Application Form

Please **enhance** my financial security with *PSAC Enhanced Coverage*!

Coughlin & Associates Ltd. | P.O. Box 3518, Station C, Ottawa, ON K1Y 4G1 | Tel: 613-237-6792 or 1-800-216-1107 | www.coughlin.ca/psac-afpc

Member information

Certificate # (IAN): AX- PSAC identification #:

Last name:

First name: Initial:

Address:

City: Province: Postal code:

Home phone #: Work phone #:

E-mail:

Date of birth: (YYYY/MM/DD) Gender: ❑ Male ❑ Female

Height: ❑ cm ❑ ft/in. Weight: ❑ kg ❑ lbs.

Language: ❑ English ❑ French

Spousal information (if applicable)

Spouse last name:

Spouse first name: Initial:

E-mail:

Date of birth: (YYYY/MM/DD) Gender: ❑ Male ❑ Female

Height: ❑ cm ❑ ft/in. Weight: ❑ kg ❑ lbs.

Children's coverage

I am applying for coverage on my child(ren) in the amount of $20,000 for each child and attest that he/she is in good health.

Last name: First name: Date of birth: (YYYY/MM/DD)

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Last name: First name: Date of birth: (YYYY/MM/DD)

Total coverage requested *(in $25,000 increments up to $250,000)*

Member coverage: $ **Spouse coverage:** $

Member's beneficiary

Singular beneficiary designation below represents 100% allocation of the most current benefit amount

Last name: First name: Date of birth: (YYYY/MM/DD)

Relationship :

The beneficiary for the spousal or children's coverage will be the member, if living, otherwise the member's estate. You must make your beneficiary designation revocable or irrevocable by checking one of the boxes below. You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary. Note: Where Quebec law applies and you have designated your spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable".

❑ Revocable ❑ Irrevocable

PSAC enhanced coverage monthly premium rates

The following are the monthly premiums for each $25,000 unit of coverage. The maximum life insurance coverage available is $250,000 for you and $250,000 for your spouse. Premiums are based on the applicant's age, gender and smoking status and ***increase as the individual progresses from one age band to the next.***

Example: The monthly premium for a 38-year-old female non-smoker requiring $100,000 of coverage (4 x $25,000) would be $9.00 (4 x $2.25). The same coverage for a 38-year-old male non-smoker would be $11.00 (4 x $2.75). When these individuals attain age 40, the woman will pay $13.00 per month (4 x $3.25), while the man will pay $15.00 per month (4 x $3.75) for the same coverage.

Age	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker
To age 34	$2.50	$3.25	$2.00	$2.50
35-39	$2.75	$3.50	$2.25	$2.75
40-44	$3.75	$6.00	$3.25	$4.25
45-49	$5.75	$7.75	$4.50	$6.50
50-55	$9.25	$13.50	$7.25	$10.25
56-60	$15.50	$22.50	$11.50	$16.50
61-66	$25.25	$28.25	$18.00	$25.75
67-70	$38.50	$61.50	$21.50	$33.00

Medical questionnaire

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

Member	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, which 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 last five years, have you had heart trouble, high blood pressure, any blood disorder, colitis, ulcers, diabetes, any thyroid disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), any mental or nervous disorder, asthma, tuberculosis or any lung disorder, cancer tumors, any kidney disorder, or blood, albumin or sugar in your urine?	❑	❑

Spouse	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, which 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 last five years, have you had heart trouble, high blood pressure, any blood disorder, colitis, ulcers, diabetes, any thyroid disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), any mental or nervous disorder, asthma, tuberculosis or any lung disorder, cancer tumors, any kidney disorder, or blood, albumin or sugar in your urine?	❑	❑

Authorization and declaration

I hereby apply for insurance and authorize the deduction from my pay the contribution I must make toward the cost of these benefits that are based on the premium rates displayed on the reverse side of thi application.

I certify that I am now actively at work full time and full pay and that the information in this form is true and complete, to the best of my knowledge.

I authorize any health care provider, other insurance company, workers' compensation board, my employer, or other persons to release and exchange information requested by Manulife Financial, when information is needed to process my application for insurance.

I agree that a photocopy of this authorization is as valid as the original.

Member signature *(mandatory)* Date

(YYYY/MM/DD)

Spouse signature *(for spousal coverage only)* Date

(YYYY/MM/DD)