

# Application for coverage



	Age	Male non-smoker	Male smoker	Female non-smoker	Female smoker
<p>The following are the monthly premiums for each \$10,000 unit of coverage. The maximum coverage available is \$500,000 for employees and \$500,000 for spouses. Premiums are based on your age, gender and smoking habits.</p> <p><b>Example: The monthly premium for a 38-year-old female non-smoker requiring \$100,000 of coverage (10 x \$10,000) would be \$6.00 (10 X \$0.60). The monthly premium for a male non-smoker the same age would be \$7.00 (10 X \$0.70).</b></p>	To age 34	\$0.60	\$1.00	\$0.50	\$0.70
	35-39	0.70	1.30	0.60	1.00
	40-44	1.00	2.10	0.90	1.60
	45-49	1.90	3.90	1.60	2.70
	50-54	3.30	6.50	2.70	4.40
	55-59	6.10	11.20	4.30	6.70
	60-64	8.60	15.10	5.70	8.40
	65-69	11.70	19.60	7.90	10.80

## MEMBER INFORMATION

Full name (first, initial, last): \_\_\_\_\_

Address: \_\_\_\_\_ Email address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Date of birth (YYYY/MM/DD): \_\_\_\_\_ Home phone number: \_\_\_\_\_ Personal identification #: \_\_\_\_\_

Gender:  Male  Female      Smoked in past 12 months?  Yes  No      Language:  English  French

Occupation: \_\_\_\_\_ Work phone number: \_\_\_\_\_ Ext.: \_\_\_\_\_

Your height: \_\_\_\_\_  ft/in.  cm      Your weight: \_\_\_\_\_  lbs.  kg

Amount of life insurance coverage requested: \_\_\_\_\_

OFFICE USE ONLY

ID # \_\_\_\_\_

Division # \_\_\_\_\_

## SPOUSAL INFORMATION (IF APPLICABLE)

Full name (first, initial, last): \_\_\_\_\_

Date of birth (YYYY/MM/DD): \_\_\_\_\_ Gender:  Male  Female      Smoked in past 12 months?  Yes  No

Spouse's height: \_\_\_\_\_  ft/in.  cm      Spouse's weight: \_\_\_\_\_  lbs.  kg

Amount of life insurance coverage requested: \_\_\_\_\_

## YOUR REVOCABLE BENEFICIARY

Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*The beneficiary for the spouse's coverage will be the employee, if living, otherwise the employee's estate.*

*Where Quebec law applies, a spouse beneficiary is irrevocable (cannot be changed) unless you make the designation revocable by checking here:  Revocable*

# Medical questionnaire

## MEDICAL QUESTIONNAIRE

### PART 1

	MEMBER	SPOUSE
(a) Within the past two years, have you received medical or surgical attention because of illness or injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) During the past five years, have you had X-rays, electrocardiograms, blood or other special tests, for other than regular medical check-ups?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Have you ever had or been told you have heart trouble, high blood pressure, stroke, any brain or nervous system disorder, any blood disorder, colitis or other intestinal disorder, liver disorder, ulcers, diabetes, tumors, any kidney or urinary tract disorder, acquired immune deficiency syndrome (AIDS) or tested positive for HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

### PART 2 – HAVE YOU OR YOUR SPOUSE:

(a) any knowledge of any condition now existing that might require you to enter a hospital or undergo any surgical, medical or psychiatric treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) ever applied for life or health insurance that has been declined, rated or modified in any way?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) been involved in the operation of an aircraft, or do you participate in any hazardous activity(ies) such as (circle activity/ies) scuba diving, skydiving, hang gliding, auto or motorcycle racing? If other, please specify	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(d) any reason to believe you are not now in first class health and free from all symptoms of disease or impairment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(e) any immediate family member with a history of diabetes, cancer, high blood pressure, heart or kidney disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

If "yes" to any answer, provide details in the space below including specific test, injury, illness or operation and doctors' names and addresses.

Member:

Spouse:

## AUTHORIZATION

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

*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 have retained a copy of this application.*

*I understand that this coverage does not take effect until approved by Canada Life.*

*For the purposes of this insurance, I permit any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person that has records or knowledge of me or my health to give any such information to the Canada Life Assurance Company, or its reinsurer(s). A photocopy of this authorization will be as valid as the original.*

Date (YYYY/MM/DD)

Member signature

Date (YYYY/MM/DD)

Spouse signature (for spouse's coverage)