

**PROTECTED "B" (when completed)**

**1. How to Apply**

- A. Spousal Disability Plan insurance coverage is available only to the following; released members, the Cadet Instructors Cadre (CIC), the Canadian Rangers, and the spouses of these and serving members who are not themselves members of the Canadian Forces Regular Force or Reserve Force Primary Reserve. If the insured qualifies for the benefit, the benefit is \$100,000.
- B. Blocks two to seven must be completed in all cases. **Please note that the Medical History in Block 6 must be completed by the Proposed Insured.** It should be noted that a medical examination may be required. If so, the Proposed Insured will be provided with instructions by the President SISIP or The Maritime Life Assurance Company.
- C. If applicable, attach a SISIP Declaration of Common Law Relationship, Form 3E.
- D. For Regular Force and Reserve Force Class "C" members, the premium plus taxes (if applicable) will be deducted from your pay account under Allotment Code L501. For all others, complete Block 8, or a CFSA Pension Deduction Authorization Card, or submit a cheque or money order payable to "The Maritime Life Assurance Company" for the Total Annual Premium Required per Block 5.B.
- E. Exclusions and Limitations

Please note that no benefit is payable for a disability:

- (1) commencing during the first twelve months of coverage from a disease, injury or health condition for which the insured spouse consulted a physician during the 24 month period immediately prior to the **date of receipt** of the application for coverage;
- (2) resulting from substance abuse, including but not limited to alcoholism and drug addiction;
- (3) resulting from committing or attempting to commit or participating in the commission of a criminal offence;
- (4) resulting from an intentionally self-inflicted injury or disease, or attempted self-destruction whether the insured spouse is sane or insane; or,
- (5) for which there is no clear objective medical evidence to confirm an identifiable underlying disease, injury or health condition.

**2. Identification and Qualifications of Proposed Insured**

- A. The proposed Insured is:  Member  Spouse
  - B. Is the Proposed Insured covered by an employer disability plan?  Yes  No
- STOP:** To continue, the answer to question 2.B., must be "NO".

**3. Member's Information**

|  |      |         |  |            |  |
|--|------|---------|--|------------|--|
| SERVICE NUMBER (SN)  | RANK | SURNAME | FIRST NAME   | INITIAL(S) | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F |
| MAILING ADDRESS  |      |         | CITY   |            | Birthdate  |
| STREET   |      |         | APT  |            | Day Month Year   |
| PROVINCE   |      |         | POSTAL CODE  |            | C.F. Enrolment Date  |
| HOME TELEPHONE ( )   |      |         | UNIT / BASE  |            | Day Month Year   |
| OFFICE TELEPHONE ( )   |      |         | <input type="checkbox"/> CF Regular <input type="checkbox"/> Class "C" <input type="checkbox"/> Class "B"<br><input type="checkbox"/> Class "A" <input type="checkbox"/> CIC <input type="checkbox"/> Ranger<br><input type="checkbox"/> Released member |            | Date of release  |
| Is your spouse a member or former member of the Canadian Forces?<br><input type="checkbox"/> No <input type="checkbox"/> Yes |      |         | If spouse is a former member indicate date of release:   |            | Occupation<br>Day Month Year                                 |
| If yes, indicate Service Number  |      |         | If spouse is a former member indicate date of release:   |            | Day Month Year   |

**4. Spousal Information (complete if Proposed Insured is the spouse)**

|  |  |                                  |                |
|--|--|----------------------------------|----------------|
| Full name of spouse  | SEX<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Birthdate                        | Day Month Year |
| Mailing Address <input type="checkbox"/> same as member above or               | Street   | Date of Marriage (if applicable) |                |
| Province   | Postal Code  | Day Month Year                   |                |
| If applicable, attach a Declaration of Common-Law Relationship, SISIP Form 3E. |  | Place of Birth                   | Occupation     |

**5. Summary of Premium Required**

| <p><b>A. Premium Rate Table</b></p> <table style="width: 100%;"> <thead> <tr> <th>Age</th> <th>Monthly</th> </tr> </thead> <tbody> <tr><td>Less than 25</td><td>\$5.50</td></tr> <tr><td>25-29</td><td>\$7.00</td></tr> <tr><td>30-34</td><td>\$10.00</td></tr> <tr><td>35-39</td><td>\$15.50</td></tr> <tr><td>40-44</td><td>\$22.00</td></tr> <tr><td>45-49</td><td>\$35.00</td></tr> <tr><td>50-54</td><td>\$60.00</td></tr> <tr><td>55-59</td><td>\$92.50</td></tr> <tr><td>60-64</td><td>\$120.00</td></tr> </tbody> </table> | Age      | Monthly | Less than 25 | \$5.50 | 25-29 | \$7.00 | 30-34 | \$10.00 | 35-39 | \$15.50 | 40-44 | \$22.00 | 45-49 | \$35.00 | 50-54 | \$60.00 | 55-59 | \$92.50 | 60-64 | \$120.00 | <p><b>B. Premium Calculation</b></p> <p>Proposed Insured's Age <input style="width: 50px;" type="text"/></p> <p>* PST (if applicable): Ontario residents 8%<br/>Quebec residents 9%</p> | <p>Corresponding Premium <input style="width: 100%; height: 20px;" type="text"/></p> <p>PST * <input style="width: 100%; height: 20px;" type="text"/></p> <p>Total Per Month <input style="width: 100%; height: 20px;" type="text"/></p> <p style="text-align: center; font-size: 1.2em;"><b>X 12</b></p> <p>Total Annual Premium <input style="width: 100%; height: 20px;" type="text"/></p> |
|--|----------|---------|--------------|--------|-------|--------|-------|---------|-------|---------|-------|---------|-------|---------|-------|---------|-------|---------|-------|----------|---|---|
| Age  | Monthly  |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |
| Less than 25   | \$5.50   |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |
| 25-29  | \$7.00   |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |
| 30-34  | \$10.00  |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |
| 35-39  | \$15.50  |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |
| 40-44  | \$22.00  |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |
| 45-49  | \$35.00  |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |
| 50-54  | \$60.00  |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |
| 55-59  | \$92.50  |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |
| 60-64  | \$120.00 |         |              |        |       |        |       |         |       |         |       |         |       |         |       |         |       |         |       |          |   |   |

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SN

6. Medical History (Completed by Proposed Insured)

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 Spouse: M/Ft. cm/in Present weight kg/lb
5. Was there a 10% change in weight during the past year? If yes, please explain reason:
6. Have you ever applied for insurance that was declined, postponed, rated or modified in any way? If yes, please explain:
7. Have you ever claimed benefits for sickness, injury or impairment? If yes, please explain:
8. Number of days lost due to sickness, injury or impairment in last two years? Member: Spouse:
9. Is future medical or surgical treatment for your active medical conditions being considered by your attending physician(s)? Please elaborate fully

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?
11. Submitted to an EKG, blood tests, x-rays, or other diagnostic tests? if yes, which tests were performed?

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?
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.
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?
15. Disorder of the eyes, ears, nose, or throat?
16. Sugar, albumin, blood or pus in urine, venereal disease (indicate type), stone or other disorder of kidney, ureters, bladder, prostate, or reproductive organs?
17. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, haemorrhoids, recurrent indigestion or other disorder of the oesophagus, stomach, intestine, liver, or gallbladder?
18. Diabetes, thyroid disorder including toxic goitre or other endocrine disorders?
19. Any disorder of the musculoskeletal system (e.g., arthritis (indicate osteo or rheumatoid), gout, neuritis, sciatica, etc. including the spine, back, or joints)?
20. Deformity, gait disorder, or amputation?
21. Disorder of skin, lymph glands, cyst, tumour (indicate benign or malignant), or cancer.
22. Allergies, anaemia or other disorder of the blood?
23. Any other illness, disease or condition not listed above?
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
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
26. Have you ever tested positive for HIV (Human Immunodeficiency Virus)?
27. Have you been immunized against the hepatitis B virus? If yes, please give year of immunization:

Have you ever:

- 28. Received treatment for alcohol and/or drug use?
29. Been charged with impaired driving, or been arrested due to the influence of alcohol and/or drugs?
30. Used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens, or any other drugs not obtained by prescription? If yes, give details:
31. Used tobacco products? If yes, average daily consumption: Member: Spouse: Total years of use: Member: Spouse:

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**7. Signature Block (to be read and signed for all submissions)**

The responses and declarations contained herein are true and complete. I realize that any material misrepresentation shall render the insurance voidable.

I hereby authorize the NDHQ/SISIP Office and The Maritime Life Assurance Company 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; and
- 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 hereby authorize a deduction from my Pay Account or such other payment method I have chosen in payment of the SISIP premiums at such rate as may from time to time be authorized. This authorization shall continue in effect until revoked in writing by me.

I understand that the new coverage(s) applied for is subject to the approval of the President SISIP and/or The Maritime Life Assurance Company. 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.

|                       |  |  |  |  |
|-----------------------|--|--|--|--|
| CF Member's Signature | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
|                       |  | Day                                      | Month                                    | Year                                     |
| Spouse's Signature    | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
|                       |  | Day                                      | Month                                    | Year                                     |

**8. Pre-Authorized Debit (PAD) Agreement**

- While the PAD is in effect, the Company will not give notice of the premiums falling due.
- All provisions of SISIP FS Policy #901102 relating to the payment or non-payment of premiums shall apply to the PAD.
- SISIP FS may change their rates from time to time and this authorization to deduct the associated monthly premiums shall remain in force until revoked by me, or by SISIP FS, in writing. This notification must be received at least twenty (20) business days before the next debit. I may obtain a sample cancellation form, or more information on my right to cancel a PAD Agreement at my financial institution or by visiting [www.cdnpay.ca](http://www.cdnpay.ca).
- I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).
- If there are more than two failed transactions in any twelve month period, the Company may terminate the PAD and bill the undersigned for annual payments in advance.

**Please complete the following:**

|  |  |
|--|--|
| 1) Type of account<br>Chequing <input type="checkbox"/> or Savings <input type="checkbox"/> AND Personal <input type="checkbox"/> or Business <input type="checkbox"/> | 4) Signature(s) of depositor(s) as shown on bank records<br><input style="width: 95%;" type="text"/> |
| 2) Day of the month to be withdrawn<br>1st of the month <input type="checkbox"/> 15th of the month <input type="checkbox"/>  | 5) Date<br><input style="width: 95%;" type="text"/><br>Day Month Year                                |
| 3) Depositor(s) name as shown on bank records (please print)<br><input style="width: 95%;" type="text"/>   | 6) Attach VOID cheque OR complete form 43E.  |

**9. SISIP 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 the NDHQ/ President, SISIP

|  |  |  |  |
|--|--|--|--|
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| Name                                     | Unit/Location                            | Telephone                                | Day Month Year                           |

**10. Approving Authority (Completed by SISIP or MLAC only)**

|  |   |  |  |  |
|--|---|--|--|--|
| <input style="width: 95%;" type="text"/> |   | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| SERVICE NUMBER                           | The Spousal Disability insurance coverage is<br><b>APPROVED / NOT APPROVED</b> effective: | Day                                      | Month                                    | Year                                     |
| <input style="width: 95%;" type="text"/> | or  | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| President SISIP                          |   | Day                                      | Month                                    | Year                                     |
|  | Group Underwriter Maritime Life   | Day                                      | Month                                    | Year                                     |

**11. SISIP OFFICE USE ONLY**

|                          |      |  |  |  |  |  |  |
|--------------------------|------|--|--|--|--|--|--|
|                          |      |  |  |  |  |  |  |
| Start<br>or<br>Terminate | L501 | Effective date of Allotment              | Premium                                  | Voucher #                                | Day                                      | Month                                    | Year                                     |
|                          |      | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
|                          |      | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
|                          |      | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
|                          |      |  |  |  |  |  | Actioned by                              |
|                          |      |  |  |  |  |  | <input style="width: 95%;" type="text"/> |
|                          |      |  |  |  |  |  | Day Month Year                           |



**SPOUSAL DISABILITY PLAN (SDP) - GROUP POLICY #901107**  
**CHANGE OF PAYMENT METHOD REQUEST**

**1. Member's Information**

Service Number \_\_\_\_\_ Rank \_\_\_\_\_ Surname \_\_\_\_\_ First Name \_\_\_\_\_ Initial(s) \_\_\_\_\_

Mailing Address \_\_\_\_\_ Street \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Home Telephone \_\_\_\_\_ Office Telephone \_\_\_\_\_

Date of Release: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**2. Identification of Insured**

The insured person is the  member  spouse

**3. Payment Options**

Please check the desired payment option, provide the required information, sign and date where indicated.

**Option 1:** Monthly by completing the request for Electronic Funds Transfer (EFT).

Manulife Financial, as the insurer of SISIP Policy #901107, is hereby requested to automatically withdraw monthly on the account described all the specimen cheque attached for the purpose of paying premiums. This authorization and request shall also apply to any other account in any Bank, Trust Company or Credit Union subsequently named by me by the provision of a specimen cheque on such new account.

It is understood that and agreed that:

- (1) While the EFT is in effect, the Company will not give notice of service fees 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 Policy #901107 relating to the payment or non-payment of premiums shall apply to the EFT.

**Please complete the following:**

- (1) Type of account and/or account number if not shown on specimen cheque \_\_\_\_\_ (2) Date of Month to be processed  1st the month  15th of the month
- (3) Depositor's name as shown on Bank records (please print) \_\_\_\_\_ (4) Signature(s) of Depositor(s) as shown in Bank records. \_\_\_\_\_
- (5) Signature of Group Certificate holder if other than in (4) \_\_\_\_\_ Date: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**Option 2:** Monthly by completing a CFSA Pension Deduction form.

**Option 3:** Annually by cheque or money order for the total annual premium (monthly premium x 12 plus PST if applicable) payable to Manulife Financial.

**4. Signature Block**

I hereby authorize a deduction, consistent with the payment method chosen, in payment of the SISIP premiums payable under Policy #901107 at such rate as may from time to time be authorized.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return to the:

President SISIP Financial Services  
National Defence Headquarters  
MGen George R. Pearkes Bldg  
Ottawa ON KIA OK2

or

SISIP Services Dept  
Manulife Financial  
PO Box 1030, 2727 Joseph Howe Dr  
Halifax NS B3J 2X5

## Important Information for you Records



### Medical information Bureau

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

If you question the accuracy of the 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.

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

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

|  |              |
|--|--------------|
| COLD LAKE                                  | 780-594-4562 |
| BAGOTVILLE                                 | 418-677-3333 |
| BORDEN/LONDON/NORTH BAY/TORONTO            | 705-424-2262 |
| EDMONTON/WAINWRIGHT/CALGARY                | 780-973-3130 |
| ESQUIMALT/COMOX/VANCOUVER/COLORADO SPRINGS | 250-363-3301 |
| GAGETOWN/MONCTON/PEI                       | 506-357-3666 |
| GREENWOOD                                  | 902-765-6714 |
| HALIFAX/SHEARWATER                         | 902-425-6926 |
| KINGSTON                                   | 613-547-1172 |
| NEWFOUNDLAND & LABRADOR                    | 709-570-8480 |
| OTTAWA                                     | 613-233-2177 |
| PETAWAWA                                   | 613-687-0025 |
| SHILO                                      | 204-765-7120 |
| ST-JEAN/MONTREAL                           | 450-357-9595 |
| TRENTON                                    | 613-965-4823 |
| VALCARTIER                                 | 418-844-0111 |
| WINNIPEG/MOOSE JAW/REGINA                  | 204-984-3222 |

**Please forward completed forms to:**

**SISIP Financial Services**  
NDHQ - 234 Laurier Avenue West, ground floor  
Ottawa, ON K1A 0K2

[www.sisip.com](http://www.sisip.com)