

1. MEMBER INFORMATION

Service Number (SN)		CFOne #		Rank	
Date of Birth (dd-mm-yyyy)	Surname		First Name		Initials M <input type="checkbox"/> F <input type="checkbox"/>
Date of Enrollment (DOE) (dd-mm-yyyy)		Primary/Day Telephone		Secondary/Evening Telephone	
Apt.		Civic #	Street		City
Province		Postal Code		Email Address	

2. MEMBER STATUS

Regular Force Primary Reserve Force Released Member

3. SMOKING/NON-SMOKING STATUS

a) Have you used tobacco or a tobacco product in the last twelve (12) months? CAF Member (M): YES NO Spouse (S): YES NO

b) Date you last used tobacco or a tobacco product?

dd	mm	yyyy
----	----	------

dd	mm	yyyy
----	----	------

4. SIGNATURE (to be read and signed for all submissions)

The responses and declarations contained herein are true and complete. I realize that any material misrepresentation will render void the insurance. I hereby authorize SISIP Financial and Manulife 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 (MIB*), 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, specified in paragraph (a); or,
c) to request a personal investigation report relating to me.

A copy 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.

The information provided on this form is protected from unauthorized disclosure under Canada's *Privacy Act*, *Personal Information Protection and Electronic Documents Act* (PIPEDA) or equivalent provincial legislation and is available to you upon request.

CAF Member's Name Printed:	<input type="text"/>	CAF Member's Signature:	<input type="text"/>	dd	mm	yyyy
I consent to being notified or contacted regarding other SISIP Financial products or services: Initial: _____ YES or _____ NO						
Spouse's Name Printed:	<input type="text"/>	Spouse's Signature:	<input type="text"/>	dd	mm	yyyy
I consent to being notified or contacted regarding other SISIP Financial products or services: Initial: _____ YES or _____ NO						

Only required if spouse stopped smoking

*MIB - to review information on your file, or have it corrected, visit www.mib.com for contact information.

5. MAILING INSTRUCTIONS

Regular Force Members	Primary Reserve Force & Released Members
Please return to: SISIP Financial 4210 Labelle Street Ottawa, ON K1A 0K2	Please return to: SISIP Life Insurance - Manulife P.O. Box 1030 2727 Joseph Howe Drive Halifax, NS B3J 2X5

6. FOR SISIP FINANCIAL OFFICE USE

Allotment Advice

Pay Allotment Code	Effective Date of Allotment			Premium	Voucher #	dd-mm-yyyy		
	dd	mm	yyyy					

Actioned by

dd	mm	yyyy
----	----	------