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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 ☐ M ☐ F

MAILING ADDRESS STREET APT | CITY | Birthdate Day Month Year

PROVINCE | POSTAL CODE | UNIT / BASE | C.F. Enrolment Date Day Month Year

HOME TELEPHONE ( ) | OFFICE TELEPHONE ( )

☐ CF Regular ☐ Class "C" ☐ Class "B"
☐ Class "A" ☐ CIC ☐ Ranger
☐ Released member

Is your spouse a member or former member of the Canadian Forces?

☐ No ☐ Yes

If yes, indicate Service Number

If spouse is a former member indicate date of release:

Occupation | Date of release Day Month Year

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

Full name of spouse | SEX ☐ Male ☐ Female | Birthdate Day Month Year

Mailing Address ☐ same as member above, or Street Apt | City | Date of Marriage (if applicable) Day Month Year

Province | Postal Code | Maiden name (if applicable)

If applicable, attach a Declaration of Common-Law Relationship, SISIP Form 3E.

Place of Birth | Occupation

5 . Summary of Premium Required

A. Premium Rate 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

B. Premium Calculation

Proposed Insured's Age

* PST (if applicable): Ontario residents 8%
Quebec residents 9%

Corresponding Premium	
PST *	
Total Per Month	
	X 12
Total Annual Premium	

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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.

Spouse Yes No

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: .... Member:............ Spouse: .... ☐ ☐
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 ______ Day Month Year

Spouse's Signature ______ 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.
→ 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.
→ 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
Chequing ☐ or Savings ☐ **AND** Personal ☐ or Business ☐

2) Day of the month to be withdrawn
1st of 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 on bank records

5) Date
Day Month Year

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

Name	Unit/Location	Telephone	Day	Month	Year
		( )			

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

SERVICE NUMBER

The Spousal Disability insurance coverage is **APPROVED / NOT APPROVED** effective: Day Month Year

President SISIP Day Month Year or Group Underwriter Maritime Life Day Month Year

11. SISIP OFFICE USE ONLY

Start or Terminate	L501	Effective date of Allotment	Premium	Voucher #	Day	Month	Year

Actioned by

Day Month Year

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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 Pre-Authorized Debit (PAD). Please affix a cheque marked "VOID" to confirm banking information. If you do not have a chequing account, please ask your bank for a counter cheque.

Manulife Financial, as the insurer of the SISIP FS Policy, is hereby requested and authorized under this PAD Agreement to debit the bank account described on the specimen cheque attached for the purpose of paying premiums. This authorization and request shall also apply to any other account in any financial institution subsequently named by me by the provision of a specimen cheque on such new account.

I will advise of any changes in this information and this authorization will remain in effect until written notification of its change or cancellation has been received from me. I understand there is no fee for this service. The information provided on this form is protected from unauthorized disclosure under Canada's *Privacy Act*, *Personal Information Protection and Electronic Documents Act* or equivalent provincial legislation and is available upon request.

It is understood that and agreed that:

– While the PAD is in effect, the Company will not give notice of the premiums falling due.
– All provisions of SISIP FS Policy #901107 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.
– 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.
– 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 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 the enclosed CFSA Pension Deduction Authorization form (ML03E/F).

☐ **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 FS 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
4210 Labelle Street
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.

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 - 4210 Labelle Street
Ottawa, ON K1A 0K2

www.sisip.com