Application for Police Pensioners Association of Ontario (PPAO)

securian CANADA

Reference number 140011

In this application *you* and *your* refer to the person applying for insurance. *We* and *the Company* refer to Canadian Premier Life Insurance Company ("Securian Canada").

Please PRINT clearly.

1. General information (complete all)

Information about you

First name	Middle initial	Last name	Former/maiden name (if applicable)

Date of birth (dd-mm-yyyy)	Province of birth	Country of birth	☐ Male ☐ Female

Address (street number and name)	Apartment or suite

City	Province	Postal code

Telephone (home)	Email address

Are you a resident of Canada and covered under the provincial health plan in your province of residence?
☐ Yes ☐ No

Are you retired?	Name of your most recent employer
☐ Yes Date of retirement (dd-mm-yyyy): ☐ No	

Are you currently covered under an employer sponsored Health Spending Account (HSA) or were you covered under an employer sponsored HSA within the last 60 days?
☐ Yes ☐ No

Please complete if applying for Spousal insurance.

Information about your spouse

First name	Middle initial	Last name	Former/maiden name (if applicable)

Date of birth (dd-mm-yyyy)	Province of birth	Country of birth	☐ Male ☐ Female

Email address

Are you a resident of Canada and covered under the provincial health plan in your province of residence?
☐ Yes ☐ No

Please complete if applying for Dependent child(ren) insurance.

Information about your dependent child(ren)

First name	Middle initial	Last name	☐ Male ☐ Female

Date of birth (dd-mm-yyyy)	Student or functionally impaired ☐ Yes ☐ No

First name	Middle initial	Last name	☐ Male ☐ Female

Date of birth (dd-mm-yyyy)	Student or functionally impaired ☐ Yes ☐ No

First name	Middle initial	Last name	☐ Male ☐ Female

Date of birth (dd-mm-yyyy)	Student or functionally impaired ☐ Yes ☐ No

If you need more space, please complete on separate sheet of paper, and sign and date it.

2. Coverage applied for

☐ **Health and Core Travel Plan**
- ☐ Single
- ☐ Couple
- ☐ Family

OR

☐ **Health, Core Travel and Dental Plan**
- ☐ Single
- ☐ Couple
- ☐ Family

3. Statement of insurability

ONLY complete section 3 if you are applying 60 days after your group insurance plan terminated.

IMPORTANT: Please answer the following questions completely and accurately. If you're not sure whether some information is relevant, provide it anyway. If you do not disclose all relevant information, claims may be denied and insurance cancelled. **Please do not tell us about genetic testing or genetic tests results. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.**

3.1 Background information

Information about you

Height ft in / m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months ☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		
Name of attending physician (if no attending physician, please state ***none***)		
Date and reason of last consultation		
Diagnosis, results, treatment given, medication prescribed		

If the attending physician named above does not have the most complete records of your medical history, please provide the full name and address of the attending physician who does have them.

Information about your spouse

Height ft in / m cm	Weight ☐ lbs ☐ kg	Change in weight in the last 12 months ☐ No change ☐ Gain: ☐ Loss: ☐ lbs ☐ kg
Reason for weight change		
Name of attending physician (if no attending physician, please state ***none***)		
Date and reason of last consultation		
Diagnosis, results, treatment given, medication prescribed		

If the attending physician named above does not have the most complete records of your medical history, please provide the full name and address of the attending physician who does have them.

3. Statement of insurability (continued)

3.2 Medication and/or treatment information

Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories or other treatment (therapy, counselling, etc.) including unfilled prescriptions?	You	Your spouse	Your dependent child(ren)
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *yes*, please complete the table below.

Name of person to be insured	Condition	Medication and/or treatment	Monthly cost	Strength	Daily dosage	Length of time
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

3.3 Health questionnaire

Do not tell us about genetic testing or genetic test results.

Have any of the persons to be insured ever:	You	Your spouse	Your dependent child(ren)
a) consulted a physician for symptoms or had treatment for cancer or tumour, neurological disorder, cardiovascular disorder, high blood pressure, stroke, diabetes, liver or kidney disease, respiratory disorder, gastrointestinal disorder, mental or nervous disorder, substance abuse, hepatitis, endocrine disorder, blood disorder, genitourinary or reproductive system disorder, rheumatoid arthritis, multiple sclerosis, immunological disorder, or tested positive for HIV?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) had any other illness, injury, operation or treatment within the last five years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) contemplated medical or surgical treatment, or a hospital stay in the next six months, and have you or your spouse in the last two years been unable to work for more than five consecutive days?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) had any symptoms and complaints for which a physician has not been consulted or been advised to have any further examinations or tests which have not been yet completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) received advice or treatment for the use of alcohol or drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) had an application for insurance declined, postponed, rescinded, cancelled or modified in any way, or been denied a renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. Statement of insurability (continued)

Please provide details below for any yes answers under sections 3.3 (a-f). Include the results of all physical examinations and check-ups.

If you need more space, please complete on a separate sheet of paper, and sign and date it.

Question	Name of person to be insured	Date (mm-yyyy)	Name and address of physician and hospital, if any	Where applicable, include all information as to the nature of illness or injury, symptoms, number of attacks, duration, treatment and results

4. Payment of premiums

a) ☐ Monthly pre-authorized debit (PAD)

Please attach a personal blank cheque, marked VOID across the front, to this application form.

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the following terms and conditions:

Terms and conditions

You authorize Canadian Premier Life Insurance Company ("Securian Canada") to collect the monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated above. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly premium (including applicable provincial tax) collected through this agreement may vary. You agree to waive the requirement that Securian Canada notify you of any payments after the first payment whether the amount of the monthly premium is changed or not. You understand that the monthly premium is due the first of each month. This agreement will be cancelled automatically if Securian Canada is unable to make a withdrawal from your account.

This authorization is to remain in effect until Securian Canada has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your financial institution or by visiting *www.payments.ca*.

Securian Canada may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

You have certain recourse rights if any debit does not comply with this agreement. For example, you 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 your recourse rights, contact your financial institution or visit *www.payments.ca*.

Securian Canada
PO Box 963 Stn A,
Toronto, ON, Canada M5W 1G5
Telephone number: 1-877-363-2773

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

Signature of account holder **X**	Date (dd-mm-yyyy)
Signature of account holder **X**	Date (dd-mm-yyyy)

b) ☐ Credit card option (charge my premium to my Visa and/or MasterCard)

Payment frequency - Monthly

Once we have approved your application, you will be contacted by a Securian Canada call centre representative to obtain your credit card information.

Terms and conditions

In connection with your required premium under this benefit plan, you authorize us to: charge your credit card for the insurance premium owing, cancel this authorization 10 days after you have provided written notice to us, and to automatically cancel this agreement if we are unable to charge your credit card.

Send no money with this application. You will be notified with a premium statement.

5. Declaration and authorization

I declare that my answers in this Application Form are true and complete and I understand that concealment, misrepresentation and false declaration concerning this Application Form will cause the insurance to be void. I hereby confirm that I am a member of PPAO in good standing on the date immediately prior to the sate of retirement, or the date group insurance plan offered by my employer or union terminated.

Applicable if proof of good health is required: I hereby certify that I have read the Medical Information Bureau (MIB) notice (see section 6), and having read the contents, I have, by the signature(s) below, authorized the MIB to give Canadian Premier Life Insurance Company ("Securian Canada"), or its reinsurers, any information it may have.

I authorize Securian Canada, and its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers, and reinsurers.

A photocopy or electronic version of this authorization is as valid as the original.

Your signature **X**		Your spouse's signature (if applicable) **X**
Location signed (city)	Location signed (province)	Date (dd-mm-yyyy)

Please return your completed application to:

Securian Canada
PO Box 963 Stn A,
Toronto, ON, Canada M5W 1G5

6. Medical Information Bureau notice

In the course of underwriting your application, Canadian Premier Life Insurance Company ("Securian Canada") may disclose information about you to its reinsurers. Securian Canada and its reinsurers may also release information in their files to other life and health insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Securian Canada or its reinsurers may also submit a brief report of their findings to the Medical Information Bureau (MIB), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If the person named in this application also applies for insurance coverage or submits a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

You may ask to see your personal information on file with MIB and correct anything that is inaccurate or incomplete.

Write to the MIB at:

Medical Information Bureau
330 University Avenue
Toronto, Ontario M5G 1R7

or call: 416-597-0590

7. Respecting your privacy

Respecting your privacy is a priority for Securian Canada. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC. ("MIB"), and other agents, governments agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *http://www.securiancanada.ca/privacy-statement.*