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| **Critical Illness Application** | | | | | |
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| **NOTES:** | **Coverage is applicable to Board Members only** | | | | |
|  | **This application must be completed for each individual applying for Critical Illness Coverage** | | | | |
|  | **If the Applicant answers "Yes" to having any of the conditions or procedures below, they are not eligible for coverage** | | | | |
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|  | |  | | | |
| Named Insured | |  | | Policy Number |  |
| Name of Individual Applicant | | |  | | |
| Mailing Address of Individual Applicant | | |  | | |
| Occupation and Title of Individual Applicant | | |  | | |
| Date of Birth (dd/mm/yy) of Individual Applicant | | |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| During the past two (2) years has the Individual Applicant received medical or surgical attention due | | | |  | |  |  |  |
| to illness or injury? | | | | YES | |  | NO |  |
| If "YES", provide details | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Declaration – Read carefully prior to signing** | | | | | | | | |
| I declare that I am a Canadian resident between the ages of 18 and 75. I declare that I have not, at any time during my life been | | | | | | | | |
| diagnosed with, had any signs and/or symptoms of, or had any medical consultations and/or abnormal tests concerning any of the | | | | | | | | |
| following: | | | | | | | | |
|  | **Heart Disease** | **Coronary Artery Bypass Surgery** | **Heart Valve Replacement** | | **Multiple Sclerosis** | | | |
|  | **Stroke** | **Paralysis** | **Brain Tumor** | | **Organ Transplant** | | | |
|  | **Cancer** | **Aorta Graft Surgery** | **Alzheimer's Disease** | |  | | | |
|  | **Kidney Disease** | **Parkinson's Disease** | **Motor Neuron Disease** | |  | | | |
|  | | | | | | | | |
| I also understand that coverage is not effective unless the Applicant's Name is specifically shown as an Insured Person with respect to | | | | | | | | |
| this specific coverage. | | | | | | | | |
|  | | | | | | | | |
| A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, | | | | | | | | |
| conditions, limitations, and exclusions of the policy wordings. | | | | | | | | |
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| **Applicant Acknowledgement** | | | | | | |
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| The undersigned authorized officer of the organization declares that, to the best of his/her knowledge, the statements set forth herein | | | | | | |
| are true. Signing of this application does not bind the Insurer to offer, nor the Applicant to accept Insurance, but, it is agreed that this | | | | | | |
| form shall be the basis of the contract should a policy be issued, and this form will be attached to and become part of the policy. | | | | | | |
|  | | | | | | |
| The undersigned, on behalf of the insured organization, acknowledges that any personal information provided in connection with this | | | | | | |
| application (including but not limited to the information contained in this form) has been collected in accordance with applicable | | | | | | |
| privacy legislation and this information shall only be used or shared by the Company to assess, underwrite and price insurance | | | | | | |
| products and related services, administer and service insurance policies, evaluate and investigate claims, detect and prevent | | | | | | |
| fraud, analyze and audit business results and/or comply with regulatory or legal requirements. | | | | | | |
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| **Applicant Name** | |  | **Title/Position** | |  |
| **Applicant Signature** | |  | **Date** | |  |
| **Broker Name** | |  |  |  | | |
| **Broker Signature** | |  |  |  | | |