

EMPLOYER SECTION

POLICY NUMBER 9226903	EMPLOYER
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APPLICANT SECTION

EMPLOYEE'S NAME		DATE OF BIRTH DD / MM / YYYY	
ADDRESS		CITY	
PROVINCE		POSTAL CODE	
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	AMOUNT OF PRINCIPAL SUM \$20,000.00	CURRENT MONTHLY PREMIUM (INCREASES WITH AGE)
HAVE YOU SMOKED ANY CIGARETTES, CIGARELLOS, CIGARS, MARIJUANA, USED PIPES OR CHEWING TOBACCO OR ANY NICOTINE PRODUCTS (PATCH, GUM) WITHIN THE PAST 12 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, PLEASE PROVIDE DETAILS	
EMPLOYEE'S SIGNATURE		DATE DD / MM / YYYY	
<input type="checkbox"/> New insurance		<input type="checkbox"/> Change in amount	
		<input type="checkbox"/> Change in name	

SPOUSE

NAME OF SPOUSE		DATE OF BIRTH DD / MM / YYYY	
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	AMOUNT OF PRINCIPAL SUM \$20,000.00	CURRENT MONTHLY PREMIUM (INCREASES WITH AGE)
HAVE YOU SMOKED ANY CIGARETTES, CIGARELLOS, CIGARS, MARIJUANA, USED PIPES OR CHEWING TOBACCO OR ANY NICOTINE PRODUCTS (PATCH, GUM) WITHIN THE PAST 12 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, PLEASE PROVIDE DETAILS	
SPOUSE'S SIGNATURE		DATE DD / MM / YYYY	
<input type="checkbox"/> New insurance		<input type="checkbox"/> Change in amount	
		<input type="checkbox"/> Change in name	

DEPENDENT CHILD

NUMBER OF CHILDREN	CHILDREN'S PRICE \$10 covers all children	AMOUNT OF PRINCIPAL SUM \$10,000.00
NAMES	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	DATE OF BIRTH DD / MM / YYYY
NAMES	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	DATE OF BIRTH DD / MM / YYYY
NAMES	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	DATE OF BIRTH DD / MM / YYYY
NAMES	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	DATE OF BIRTH DD / MM / YYYY
EMPLOYEE'S SIGNATURE		DATE
<input type="checkbox"/> New insurance		<input type="checkbox"/> Change in amount
		<input type="checkbox"/> Change in name

AUTHORIZATION

<input type="checkbox"/> I authorize the deduction from my salary of the premiums for the insurance applied for as shown above.	
EMPLOYEE'S SIGNATURE	DATE DD / MM / YYYY



Guaranteed Critical Illness Coverage Pre-Authorized Cheque (PAC) Agreement

BANKING DATA		
Branch No. (5 figures)	Institution (3 figures)	Account No. (12 figures)
Name as shown on bank records		
CustomCare Inc. is authorized to draw a cheque for monthly recurring payments in accordance with its Pre-authorized cheque plan and to exchange personal information with the financial institution in order to execute this agreement. NOTE: Transaction fees may be charged for any cheque that is not honoured by your financial institution. I confirm that the banking information accurately corresponds to my account.		
Signature (as shown on bank records)		Other signature (joint account)



PLEASE ATTACH A VOID CHEQUE WITH THIS APPLICATION

You have certain recourse right 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.cdnpay.ca.



Coverage Provided By

CustomCare Inc.

340 - 50 Avenue SE, Calgary, Alberta T2G 2B1
(403)640-6620 or 1-866-820-2188