canada life™

OPTIONAL LIFE APPLICATION FORM
EVIDENCE OF INSURABILITY

Coverage Detail

Clear | Print

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

To be completed first by the plan member.

- Sections 1-2: Fill out your name, make your coverage election for yourself and/or your spouse, complete our optional life beneficiary designation and sign and date the bottom of the form.
- Section 3-4: **Only** complete these sections if you wish to apply for insurance **above the $30,000 or if you are applying more than 31 days after** you become eligible for benefits. Please put the medical questionnaire in a sealed envelope and attach it to the Coverage Detail form.
- Return all forms to: IATSE Canadian Health Plan Administration, J&D Benefits, 228-8901 Woodbine Avenue, Markham ON L3R 9Y4. **Retain a copy for your files.**

To be completed by the plan administrator.

- Sections 1-2: Provide plan name, division number, member ID and group policy number. Review the Coverage Detail, sign and date section 1.
- Mail the completed original documents to: Group Medical Underwriting, Canada Life, PO Box 6000, Winnipeg MB R3C 3A5.

Section #1 Member's Information

Name of I.A.T.S.E. Local	Policy No.	Division No.	Benefit Class
TRUSTEES OF THE MOTION PICTURE WORKERS HEALTH BENEFITS	164651	1	A

Member Last Name	First Name	Middle Initial	ID No.

Date of Employment	Annual Earnings	Plan Administrator's Name	Plan Administrator's Phone No.	Plan Administrator's Email Address
MMM/DD/YYYY		J&D Benefits Inc	XXX-XXX-XXXX	benefitsoffilm@jdbenefits.com

Plan Administrator's Authorization	Date Authorized
☐ I hereby certify that the information on this Coverage Detail form is accurate.	MMM/DD/YYYY

Section #2 Coverage Election Section *Completed by Member*

Optional Life is available in units of $5,000 up to a maximum of $500,000 per individual. **You may purchase up to $30,000 of Optional Life coverage for you and/or your spouse/partner without medical evidence** (must be applied for within 31 days of becoming eligible - contact your Plan Adminisrator for details). Additional coverage above $30,000 is subject to medical evidence, or if you are applying after the 31 day eligibility period.

To apply for Optional Life Insurance:

1. Fill out the amount of Optional Life Insurance you already have under this plan as the Member Current Amount.
2. Fill out the amount of additional Optional Life Insurance you want to purchase as the Additional Amount Requested, complete the beneficiary designation, and sign and date the form.
3. If you wish to purchase more than $30,000.00 of coverage, or if you are applying after the 31 day eligibility period, Medical & Lifestyle Questionnaire must be completed. (Sections 3 & 4)

Member Current Amount:	$	Spouse Current Amount:	$
Additional Amount Requested:	$	Additional Amount Requested:	$
Total Amount Applied for:	$	Total Amount Applied for:	$

Age Band	Males		Females	
	Non-Smoker	Smoker	Non-Smoker	Smoker
< 25	$0.05	$0.10	$0.03	$0.04
25 - 29	$0.05	$0.10	$0.03	$0.04
29 - 34	$0.05	$0.10	$0.03	$0.04
35 - 39	$0.05	$0.11	$0.04	$0.06
40 - 44	$0.07	$0.18	$0.06	$0.10

Age Band	Males		Females	
	Non-Smoker	Smoker	Non-Smoker	Smoker
45 - 49	$0.12	$0.33	$0.10	$0.18
50 - 54	$0.22	$0.56	$0.16	$0.29
55 - 59	$0.41	$0.95	$0.26	$0.44
60 - 64	$0.55	$1.27	$0.32	$0.53
65 - 69	$0.91	$2.10	$0.53	$0.88

Monthly rates are per $1,000 of coverage. Example, Male, non-smoker, age 52, purchasing $30,000 of coverage 30,000 / $1,000 x 0.22 = $6.60 monthly premium ($79.20 annually).

M5995(IATSE-JD)-2/20

Optional Life Beneficiary Designation

Completed by Member

This section must be completed to designate a beneficiary for your life benefits, if applicable. **The original of this form will be required for a life claim. Crossed out beneficiary designations must be initialed. Please print clearly, in INK.**

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

First Name	Last Name	Middle Initial	Percent allocated	Relationship to member

To be divided as follows: ☐ As per the percentage indicated above, or ☐ In equal shares to the survivor(s)

▶ The Beneficiary for the spousal or child coverage shall be the member if living, otherwise the estate. I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

NOTE: Where Quebec law applies: and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked “Revocable”, below.

I hereby make the above beneficiary designation: ☐ Revocable, I may change this beneficiary at any time

▶ An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without consent of the revocable beneficiary.

Smoking Declaration

Completed by Member

Within the past 12 months have you smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco or nicotine products in any other form?

	YES	NO
MEMBER	☐	☐
SPOUSE	☐	☐

Plan Member’s Signature

Signature	Date
	MMM/DD/YYYY

canada life™

EVIDENCE OF INSURABILITY

Applicant Information

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

Sections 3 & 4: Only complete these sections if you wish to apply for insurance **above the $30,000 or if you are applying more than 31 days after** you become eligible for benefits. Please put the medical questionnaire in a sealed envelope and attach it to the Coverage Detail page.

Section #3 Member and Dependant Details *Completed by the Member*

Member Information

Name of I.A.T.S.E. Local	Policy No.
TRUSTEES OF THE MOTION PICTURE WORKERS HEALTH BENEFITS	164651

Member Last Name	First Name	Middle Initial	Gender
			☐ Male ☐ Undisclosed ☐ Female ☐ Other

Date of Birth	Occupation	Job Duties
MMM/DD/YYYY		

Home Mailing Address Street	City	Province	Postal Code

Email Address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Home Phone Number	Best time to call	Alternate Contact Number	Extension	Best time to call
XXX-XXX-XXXX	☐ Day ☐ Evening	XXX-XXX-XXXX	XXXX	☐ Day ☐ Evening

Spouse Information (if applicable) - *only required if you are applying for dependant coverage.*

Spouse Last Name	First Name	Middle Initial	Gender
			☐ Male ☐ Undisclosed ☐ Female ☐ Other

Date of Birth	Occupation	Job Duties
MMM/DD/YYYY		

Email Address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Home Phone Number	Best time to call	Alternate Contact Number	Extension	Best time to call
XXX-XXX-XXXX	☐ Day ☐ Evening	XXX-XXX-XXXX	XXXX	☐ Day ☐ Evening

YOU SHOULD NOT TELL US ABOUT ANY GENETIC TEST WHICH YOU MAY HAVE HAD DONE. YOU MUST HOWEVER, TELL US IF YOU ARE HAVING TREATMENT FOR, OR EXPERIENCING SYMPTOMS OF A GENETIC CONDITION.

Section #4 Personal Medical History and Lifestyle Information

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 7 - Additional Details at the end of this document and provide the number of the question.**

MB = Member **SP** = Spouse

1. Do you now have or have you ever had: cancer, heart disease, diabetes, arthritis, any neurological, psychiatric, intestinal or respiratory disorders, or any other chronic medical condition(s)?	Yes No MB ☐ ☐ SP ☐ ☐	Please describe medical condition, including the date of onset and duration.
2. Have you ever tested positive for hepatitis or HIV?	Yes No MB ☐ ☐ SP ☐ ☐	Please describe which test, why you had it and when.
3. Have you ever had an MRI or CT scan?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide approximate year, describe for what reason(s) and the results.
4. Have you ever stayed overnight in a hospital?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide approximate year, duration of stay and medical diagnosis.
5. Have you ever received workers' compensation or sickness disability benefits for more than 7 consecutive days?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide the approximate date that you left work, duration off work and medical condition.
6. Have you ever missed more than 10 days from work or school for illness or injury other than that described in question 5?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide date and describe the medical condition, if not already described above.
7. Have you ever had an application for insurance declined or modified?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide approximate year and describe for what reason(s).
8. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?	Yes No MB ☐ ☐ SP ☐ ☐	Please describe the reason.
9. In the last 12 months have you been taking any prescription medication?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide name of medication, dosage, duration, and medical condition for which you are taking/took it.
10. Have you ever been advised to drink less alcohol by your physician, or used drugs (including marijuana) for non-medical reasons in the last 10 years?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide details of when, which product used, and frequency of use per week.
11. Do you drink alcohol?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide type of alcohol and quantity per week.
12. Within the past 12 months have you smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco, or nicotine products in any other form?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide which product you use, how much/many per day.

Section #4 Personal Medical History and Lifestyle Information *...continued*

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 7 - Additional Details at the end of this document and provide the number of the question.**

MB = Member **SP** = Spouse

13. Have you gained or lost more than 10 pounds in the last 12 months?	Yes No MB ☐ ☐ SP ☐ ☐	Please specify weight loss or gain, amount of change in weight, and reason.
14. Current height and weight: MEMBER: _____ m/cm or _____ feet/inches _____ kg or _____ pounds SPOUSE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds		
15. Do you have a regular healthcare provider? If yes, please advise (in section to the right) Provider's name, address and date and reason of last appointment.	Yes No MB ☐ ☐ SP ☐ ☐	
16. Have you been referred to any medical specialists in the last 2 years?	Yes No MB ☐ ☐ SP ☐ ☐	Please provide the name of specialist, type of specialty and medical reason for visit.
17. Do you, or are you planning to, participate in hazardous activities such as parachute jumping, hang-gliding, scuba diving, aviation or motorized racing?	Yes No MB ☐ ☐ SP ☐ ☐	Please describe the type and frequency of the activity.
18. Please describe weekly exercise including type of activity, duration and frequency.		

Family History

19. For each applicant, do your parents, siblings, spouse or children suffer or have suffered from any of the following:

- Alzheimer's Disease
- Amyotrophic lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Cancer
- Cardiomyopathy
- Dementia
- Diabetes
- Heart Disease
- Huntington's chorea
- Motor Neuron disease
- Multiple Sclerosis
- Parkinson's Disease
- Polycystic Kidney disease
- Retinitis Pigmentosa
- Stroke
- and/or any other hereditary medical condition

Member: ☐ **Yes** ☐ **No** **Spouse:** ☐ **Yes** ☐ **No**

If yes, please complete the appropriate section below. Use extra paper if required.

Member (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Spouse (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Please provide any additional information that you feel is important:

Notice About MIB Inc.

IMPORTANT NOTICE

Your personal information will be treated as confidential. Canada Life or its reinsurer(s) may, however, make a brief report to the MIB Inc., a non-profit membership organization of 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 or submit a claim for benefits to such a company, the bureau will upon request supply the company with the information it may have.

Canada Life or its reinsurer(s) may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The company will not, however, reveal to another company or to the bureau the action taken on the basis of your current request for insurance.

If you wish to see the information in your bureau file or have it corrected, please contact the bureau's information office at:

Suite 501, 330 University Avenue, Toronto ON M5G 1R7, Tel 416.597.0590

Protecting Your Personal Information

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.*The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.*

If you want to know more:

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Authorization and Declarations

I authorize:

- Canada Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, the MIB Inc., administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life to exchange personal information, when necessary to determine my insurability and to administer the group benefits plan;
- Canada Life to have performed tests, examinations, blood profiles and urinalysis tests as may be required to determine my insurability in connection with this application;
- Canada Life to release my medical records to the regular healthcare provider or clinic named in this application including any test results that may be obtained during the application process;
- Canada Life to communicate with me about this application using the email address I have provided;
- My plan sponsor to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable.

I certify or confirm that:

- I am actively at work on the date this application is signed;
- I have read and agree with the Important Notice describing the procedures of the MIB Inc.;
- I have retained a copy of this application;
- If applying for coverage for dependents, I am authorized to act on their behalf;
- A photocopy or an electronic copy of this authorization is as valid as the original.

The statements and answers on this form will be used to determine your insurability and to provide benefits under the plan. Any changes in the accuracy of any of the statements and answers on the form between the date this form is signed and the effective date of any coverage approved by Canada Life must be reported to Canada Life. I understand that if I fail to do so, any coverage granted may be void.

I declare that to the best of my knowledge, all of the above answers to the questions are complete and true. I understand that if any answer is incomplete or false, any coverage granted may be void. I understand that I may be refused for coverage for all or part of any benefit if, in the opinion of Canada Life, I am not insurable for all or part of that benefit.

For Quebec Applicants: I request that all communication and documents be in English.
Je demande à ce que toutes les communications et tous les documents soient en anglais.

Member Signature _____ Date Signed _____
MMM/DD/YYYY

Spouse Signature _____ Date Signed _____
MMM/DD/YYYY

Clear Print

Additional Details

This page is to be used if you require **extra space to respond to a question.**
Provide the number of the question you are addressing.

MB = Member **SP** = Spouse

Question #	Details