CHUBB®

GROUP INSURANCE PLAN
OPTIONAL CRITICAL ILLNESS ENROLLMENT FORM

GROUP POLICY INFORMATION

Policyholder Name:	**Policy #: CO**

EMPLOYEE INFORMATION

Last Name:	**First Name:**		**Telephone #: ( )**
Date of Birth:		**Gender:**	
Address - Street:	**City:**	**Province:**	**Postal Code:**

SPOUSAL INFORMATION (Only to be completed if applying for Coverage)

Last Name:	**First Name:**	**Date of Birth:**	**Gender:**

DEPENDENT INFORMATION (Only to be completed if applying for Coverage)

Last Name	First Name	Birthdate (D/M/Y)	Gender (M/F)	Dependent Children (< age 21)	Full-Time Student (< age 25)	Disabled Dependent (> age 21)
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

COVERAGE SELECTION – Please refer to the Critical Illness Product summary page for Benefit Levels available and Rate Chart

	Employee	Spouse	Dependent Children*
Smoker Status	☐ **Smoker or** ☐ **Non-Smoker**	☐ **Smoker or** ☐ **Non-Smoker**	**n/a**
Benefit Amounts Selected	**$**	**$**	☐ $5,000 **or** ☐ $10,000
Monthly Premium (see Rate Chart)	**$**	**$**	**$**

*Only available in conjunction with the enrollment of the employee and/or spouse

BENEFICIARY DESIGNATION

All benefit payments, including benefits payable for any insured dependent child covered under this plan, if applicable are paid directly to you. If you are deceased at the time that a benefit becomes payable, we will pay benefits to the beneficiary you named below. If you do not designate a beneficiary we will use the beneficiary designation made under the Policyholder's Group Life Insurance Policy. Failing such designation, all benefits will be paid to your Estate.

I appoint the following revocable beneficiary (Irrevocable in the province of Quebec) for Insurance benefits payable as a result of this plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary.

Please Note: In the province of Quebec, if you have designated your married or civil union spouse as beneficiary, the designation will be considered irrevocable unless you check here: ☐ Revocable.

	Full Legal Name	Relationship to Insured (or minor for Trustee)
Primary Beneficiary		
Contingent Beneficiary		
Trustee (for minor beneficiary)		

PRIVACY STATEMENT

At Chubb Life, we are committed to protecting our customers' privacy. Chubb Life's policy is to limit access to customer information to those who need it to serve customers' insurance needs and to maintain and improve customer service. The information provided by customers is required by us, our reinsurers and authorized administrators to assess customers' entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, we, our reinsurers and authorized administrators consult existing insurance files about customers, collect additional information about and from customers, and where required, collect information from and exchange information with, third parties. We do not disclose customer information to third parties other than our agents and brokers, except as necessary to conduct business, e.g., processing claims or as required by law. We advise customers that, in some instances, employees, service providers, agents, reinsurers, and any of their providers, of Chubb and/or Chubb Life may be located in jurisdictions outside Canada and that customers' personal information may thus be subject to the laws of those foreign jurisdictions.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

AUTHORIZATION

I hereby apply for coverage under the Group Insurance Plan, underwritten by Chubb Life Insurance Company of Canada, for which I am eligible and authorize any required payroll deductions for administration of my benefits. I certify that the information provided herein is true, accurate and complete.

Signed at _____ **this** _____ **day of** _____ **20** _____

_____ _____

Employee's Signature | Spouse's Signature (if applicable)

If APPLYING FOR COVERAGE AMOUNTS HIGHER THAN THE GUARANTEED ISSUE LEVEL PLEASE COMPLETE PAGE 2

****HEALTH QUESTIONNAIRE FOR COVERAGE AMOUNTS HIGHER THAN GUARANTEED ISSUE AMOUNT****

IMPORTANT Note: Review all questions before completing; if you would answer "YES" to any of the following questions you are only eligible for the Guaranteed Issue amounts, and should only complete Page 1 of the enrolment form.

		Employee		Spouse	
		Yes	No	Yes	No
1.	Have you ever sought advice or received treatment for, or had any known indication of:				
	a) Stroke (including transient ischemic attack), heart attack, coronary artery disease, severe valvular heart disease e.g. aortic stenosis, or any type of cardiac surgery?	☐	☐	☐	☐
	b) Cancer, tumour or malignancy?	☐	☐	☐	☐
	c) Advanced ophthalmic disease?	☐	☐	☐	☐
	d) Multiple sclerosis or paralysis?	☐	☐	☐	☐
	e) Any chronic or progressive disease or disorder of the kidney, lung, liver, pancreas or bone marrow that may lead to the failure of the organ or that may require transplantation?	☐	☐	☐	☐
	f) AIDS, HIV, chronic or unexplained infections?	☐	☐	☐	☐
2.	Within the last 5 years have you had; or been diagnosed with, or had any known indication of, a medical problem with respect to the following:				
	a) Untreated or uncontrolled high blood pressure, angina, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of, a cardiac event?	☐	☐	☐	☐
	b) Diabetes, digestive or intestinal disorder, excluding functional disorders e.g. Irritable Bowel Syndrome?	☐	☐	☐	☐
	c) Hospitalized due to a medical problem with respect to severe respiratory disorder?	☐	☐	☐	☐
	d) Used habit forming drugs, or received treatment or medical advice due to the use of drugs or alcohol?	☐	☐	☐	☐
3.	Have you ever been declined for life insurance or offered coverage only at higher than standard rates?	☐	☐	☐	☐
4.	Have you ever sought advice or received treatment for, or had any known indication of:				
	a) Advanced loss of hearing?	☐	☐	☐	☐
	b) Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorders?	☐	☐	☐	☐
	c) any psychiatric disorder, mental deterioration or loss of intellectual ability?	☐	☐	☐	☐
	d) Gout, Arthritis, Scleroderma, Muscular Dystrophy, Ataxia, Systemic Lupus Erythematosus, transverse myelitis, myasthenia gravis, post-polio syndrome, sarcoidosis or cystic fibrosis?	☐	☐	☐	☐
	e) Amputation due to disease?	☐	☐	☐	☐
5.	Do you currently:				
	a) Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, oxygen, motorized cart or stair lift?	☐	☐	☐	☐
	b) Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence?	☐	☐	☐	☐
	c) Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?	☐	☐	☐	☐
6.	Does your height and weight fall outside the chart noted below?	☐	☐	☐	☐

Males						Females					
Height	Min. Weight	Max Weight	Height	Min Weight	Max Weight	Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4' 8"	95	145	5' 8"	132	207	4' 8"	86	145	5' 8"	119	207
4' 9"	98	150	5' 9"	137	213	4' 9"	88	150	5' 9"	123	213
4' 10"	100	155	5' 10"	141	219	4' 10"	90	155	5' 10"	127	219
4' 11"	103	160	5' 11"	145	225	4' 11"	93	160	5' 11"	131	225
5' 0"	105	165	6' 0"	150	233	5' 0"	95	165	6' 0"	135	233
5' 1"	108	170	6' 1"	155	241	5' 1"	97	170	6' 1"	140	241
5' 2"	111	175	6' 2"	160	249	5' 2"	100	175	6' 2"	144	249
5' 3"	114	180	6' 3"	165	257	5' 3"	103	180	6' 3"	149	257
5' 4"	118	185	6' 4"	170	265	5' 4"	106	185	6' 4"	153	265
5' 5"	121	190	6' 5"	175	272	5' 5"	109	190	6' 5"	158	272
5' 6"	124	195	6' 6"	180	279	5' 6"	112	195	6' 6"	162	279
5' 7"	128	201	6' 7"	185	285	5' 7"	115	201	6' 7"	167	285

By signing Page 1 of this form you certify that the medical information provided herein is true, accurate and complete.