



Enrollment Form Guaranteed Critical Illness Coverage

EMPLOYER SECTION

POLICY NUMBER	DIVISION / UNIT
EMPLOYER	

APPLICANT SECTION

EMPLOYEE'S NAME	PROVINCE OF RESIDENCE
-----------------	-----------------------

EMPLOYEE

NAME OF APPLICANT	DATE OF BIRTH <small>DD / MM / YYYY</small>
GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	AMOUNT OF PRINCIPAL SUM \$20,000.00
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	
SIGNATURE	DATE <small>DD / MM / YYYY</small>
<input type="checkbox"/> New insurance <input type="checkbox"/> Change in amount <input type="checkbox"/> Change in name	

SPOUSE

NAME OF APPLICANT	DATE OF BIRTH <small>DD / MM / YYYY</small>
SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	AMOUNT OF PRINCIPAL SUM \$20,000.00
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	
SIGNATURE	DATE <small>DD / MM / YYYY</small>
<input type="checkbox"/> New insurance <input type="checkbox"/> Change in amount <input type="checkbox"/> Change in name	

DEPENDENT CHILD

NUMBER OF CHILDREN	AMOUNT OF PRINCIPAL SUM \$10,000.00
NAMES	SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker
NAMES	SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker
NAMES	SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker
EMPLOYEE'S SIGNATURE	DATE <small>DD / MM / YYYY</small>
<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. <input type="checkbox"/> I have been given the opportunity to apply for this insurance but I do not desire to participate.	
EMPLOYEE'S SIGNATURE	DATE <small>DD / MM / YYYY</small>

Critical Illness Coverage



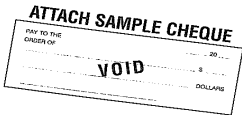
Pre-Authorized Cheque (PAC) Agreement

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))

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

Contact: CustomCare Inc. #210, 200 Quarry Park Blvd. SE – Calgary, AB. T2C 5E3 (403) 640-6620 Toll Free 1-866-820-2188