ACCIDENTAL DEATH AND DISMEMBERSHIP PROGRAM
APPLICATION

PLAN Requested coverage	A1☐	A2☐	A3☐	B1☐	B2☐	B3☐
MONTHLY PREMIUM	$10.50	$15.50	$15.50	$4.50	$6.50	$6.50
EMPLOYEE	$250,000	$250,000	$250,000	$100,000	$100,000	$100,000
SPOUSE	NONE	$150,000	$125,000	NONE	$60,000	$50,000
EACH CHILD	NONE	NONE	$37,500	NONE	NONE	$15,000

ELIGIBILITY: A DEPENDENT CHILD IS NOT MARRIED, UNDER AGE 23 OR UNDER AGE 26 IF ATTENDING AN INSTITUTION OF HIGHER LEARNING AS A FULL-TIME STUDENT. INSURED DEPENDENT CHILDREN MUST BE DEPENDENT UPON THE APPLICANT FOR MAINTENANCE AND SUPPORT AND NOT EMPLOYED AT A REGULAR FULL- TIME JOB. A PHYSICALLY OR MENTALLY DISABLED CHILD, TOTALLY DEPENDENT UPON YOU FOR SUPPORT, MAY BE COVERED REGARDLESS OF AGE.

ALL COVERAGE STARTS ON THE FIRST OF THE MONTH FOLLOWING RECEIPT OF THE APPLICATION AND TERMINATES AT AGE 70

PERSONS TO BE INSURED	ONLY NAMES OF PERSONS TO BE COVERED	BIRTHDATE MM	DD	YY	BENEFICIARY NAME	RELATIONSHIP TO APPLICANT
EMPLOYEE	NAME					
SPOUSE	NAME				APPLICANT EMPLOYEE	
CHILD 1	NAME				APPLICANT EMPLOYEE	
CHILD 2	NAME				APPLICANT EMPLOYEE	
CHILD 3	NAME				APPLICANT EMPLOYEE	
CHILD 4	NAME				APPLICANT EMPLOYEE	

EMPLOYEE APPLICANT			
NAME			
ADDRESS	CITY	PROV.	
SOCIAL INSURANCE NUMBER		HOME ( )	
EMPLOYER		OFFICE ( )	

I declare that the information in this Application for insurance is true and complete. I authorize the use of my Social Insurance Number for identification purposes only. Confirmation of coverage and policy wordings will be mailed to you within 30 days.

Dismemberment benefits are subject to the schedule in the policy.

I ENCLOSE A CHEQUE DEPOSIT (MONTHLY PAYMENT TIMES TWO) AS INDICATED ABOVE AND A BLANK CHEQUE MARKED VOID.

I AUTHORIZE ADRIATIC INSURANCE TO WITHDRAW FUTURE MONTHLY CHEQUES UNTIL I PROVIDE NOTIFICATION IN WRITING TO STOP COVERAGE AND MONTHLY WITHDRAWALS (30 DAYS NOTICE IS REQUIRED).

SIGNATURE OF APPLICANT	X	DATE

PLEASE RETURN APPLICATION AND CHEQUES TO

ADRIATIC INSURANCE BROKERS LTD.
10 DIRECTOR COURT, SUITE 100,
WOODBRIDGE, ONTARIO, L4L 7E8

JOE CAPOGNA Ex.2266

PHONE 1(800) 267 7636
(905) 851 8555
FAX (905) 851 9115

☐ DEPOSIT CHEQUE (MONTHLY TIMES 2) **(PAYABLE TO ADRIATIC INSURANCE)**
☐ BLANK CHEQUE MARKED VOID
☐ THIS APPLICATION **(PLEASE MAKE A COPY FOR YOUR RECORDS)**

ADRIATIC USE
DATE RECEIVED___ ___ ___
ENTERED ☐ POLICY☐
INITIALS ___________

ACCIDENTAL DEATH AND DISMEMBERSHIP PROGRAM

AUTOMATIC CHEQUE WITHDRAWAL PLAN
AMERICAN HOME ASSURANCE
ACCIDENTAL DEATH AND DISMEMBERMENT
SPONSORED PROGRAM
ADRIATIC INSURANCE BROKERS LTD.

I/WE AUTHORIZE
The financial institution indicated below to make payments to ADRIATIC INSURANCE BROKERS LTD.

ADRIATIC INSURANCE BROKERS LTD. to request payment of premiums due for the insurance coverage applied for on the application.

I/WE AGREE THAT:

Any request for payment submitted on the above basis will be treated as if the request has been personally signed by the Account Holder(s) / Depositor(s).

Any delivery of this authorization to the financial institution constitutes delivery by me/us.

This payment method may be cancelled by providing 30 days written notice to ADRIATIC INSURANCE BROKERS LTD.

ACCOUNT NUMBER CHEQUING PRIVILEGES	
BANK NAME	
BANK ADDRESS	
TRANSIT NUMBER	
POLICY NUMBER IF ISSUED	
ACCOUNT HOLDER(S) DEPOSITOR(S) NAME(S)	
DEPOSITOR'S SIGNATURE	☐
SIGNATURE (IF 2) DEPOSITORS	☐
DATE	

☐ **ATTACH A VOID CHEQUE**
☐ **DEPOSIT CHEQUE (MONTHLY TIMES 2)**

PAYABLE TO

ADRIATIC INSURANCE BROKERS LTD.

10 Director Court, Suite 100,
Woodbridge, Ontario. L4L 7E8