

Group Number  
536

HEATING REFRIGERATING AND AIR CONDITIONING  
INSTITUTE OF CANADA  
APPLICATION FOR CRITICAL ILLNESS



1. **MEMBER INFORMATION** Select amount of coverage desired.  \$25,000  \$50,000  \$75,000

First Name and Middle Initial \_\_\_\_\_ Last Name (include maiden name [in brackets], if applicable) \_\_\_\_\_  Male  Female

Address - Street/Apt. No. \_\_\_\_\_ City/Town \_\_\_\_\_ Province/Territory \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth (dd/mm/yy) \_\_\_\_\_ Place of Birth \_\_\_\_\_ Residence Telephone Number \_\_\_\_\_

Occupation \_\_\_\_\_ Association Membership Number: \_\_\_\_\_

2. **SPOUSAL INFORMATION** (IF APPLYING FOR SPOUSAL COVERAGE) Select amount of coverage desired.  \$25,000  \$50,000  \$75,000

First Name and Middle Initial \_\_\_\_\_ Last Name (include maiden name [in brackets], if applicable) \_\_\_\_\_  Male  Female

Address - Street/Apt. No. \_\_\_\_\_ City/Town \_\_\_\_\_ Province/Territory \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth (dd/mm/yy) \_\_\_\_\_ Place of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

3. **BENEFICIARY DESIGNATIONS**

The beneficiary of Critical Illness coverage is the Insured, if living.

In the event of the Insured's death, any applicable proceeds will be payable to the named beneficiary(ies). If no beneficiary is named, proceeds will be payable to the Insured's estate. If the beneficiary(ies) named below does (do) not survive the Insured, any proceeds will be payable to the Insured's estate. If, however, more than one beneficiary is named, the proceeds shall be paid to the surviving beneficiary (ies). If the beneficiary is under age 18, please provide the name of a Trustee.

NOTE: Spousal designation in Quebec is irrevocable unless "revocable" is specifically written below.

Indicate the name(s) of the designated beneficiary(ies) in full below.

Name of Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

Member \_\_\_\_\_

Spouse \_\_\_\_\_

4. **MEDICAL QUESTIONS**

Member	Spouse
4.1a) Name and address of personal Physician or Doctor last Consulted _____	4.1b) Name and address of personal Physician or Doctor last Consulted _____
4.2a) Date and reason for last consultation _____	4.2b) Date and reason for last consultation _____
4.3a) Height _____ <input type="checkbox"/> ft/in <input type="checkbox"/> cm Weight _____ <input type="checkbox"/> lb <input type="checkbox"/> kg	3.3b) Height _____ <input type="checkbox"/> ft/in <input type="checkbox"/> cm Weight _____ <input type="checkbox"/> lb <input type="checkbox"/> kg
4.4a) In the past year, weight has <input type="checkbox"/> Remained same <input type="checkbox"/> Increased <input type="checkbox"/> Decreased Reason for change: _____	4.4b) In the past year, weight has <input type="checkbox"/> Remained same <input type="checkbox"/> Increased <input type="checkbox"/> Decreased Reason for change: _____

Complete all questions below.

	Member		Spouse	
	Yes	No	Yes	No
4.5 Have you ever suffered from, received treatment, medication, medical advice, care, service or diagnosis for, had known indication of, had positive test for, or consulted a physician about:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a) Cancer or tumour, enlarged glands, leukemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Any disease or disorder of the immune system; such as but not limited to Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Abnormal blood pressure, stroke, any disease or disorder of the heart or circulation (such as but not limited to chest pain, angina, heart failure, heart attack) or lungs (such as but not limited to emphysema)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Any disease or disorder of the brain or nervous or neurological system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Any chronic disease or uninvestigated complaint or disorder of the stomach, intestines or colon, liver, kidney, bladder, breasts or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Diabetes, hepatitis, hepatitis carrier state, chronic disease or uninvestigated complaint or disorder of the thyroid, glands, blood, skin, muscles or bones?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.6 In the past 5 years, have you suffered from, received treatment, medication, medical advice, care, service or diagnosis for, had known indication of or consulted a physician about:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a) Any nervous illness including depression or psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Alcohol or substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.7 Within the past two years, have you:				
a) Been admitted to a hospital or clinic for longer than three consecutive days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Been advised to have further examination, diagnostic testing, treatment, or surgery that has not yet been scheduled or completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Had any abnormal test results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.8 Are you currently:				
a) Receiving disability benefits, worker's compensation or disability pensions from any source?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Aware of any symptoms for which you have not consulted a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Under the care of a physician, receiving treatment and/or medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.9 Have you:				
a) Within the past twelve months, used any products containing nicotine (including but not limited to cigarettes, cigars, pipes, smokeless tobacco, nicotine gum, the nicotine patch or other smoking cessation products)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Ever been advised to quit smoking for health reasons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.10 Have you ever had a new or reinstatement application for health care, life, disability, creditor, or critical illness insurance rated, modified, declined, postponed, withdrawn, or rescinded?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Remember to complete both sides.

**4. MEDICAL QUESTIONS (CONT.)**

**DETAILS TO MEDICAL QUESTIONS**

For every 'yes' answer given in questions 4.5 to 4.10, please provide full details. If more space is required, attach a separate sheet (signed and dated).

Proposed Insured	Question Number	Details

	Member		Spouse	
	Yes	No	Yes	No
4.11 Have any of your immediate family members (father, mother, siblings) had cancer (specify type), heart disease, stroke, diabetes, kidney disease, Huntington's Chorea, or any other hereditary disease prior to age 60? If 'yes', provide details in the chart below.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Member	Family Member	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death (if cancer specify type)

Spouse	Family Member	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death (if cancer specify type)

**5. PAYMENT METHOD**

- Option 1 - Invoice**       Annual       Semi-Annual
- Option 2 - Monthly**      Monthly Pre-Authorized Chequing (include a "VOID" cheque")
- Option 3 - VISA**       Annual       Semi-Annual       Monthly

\_\_\_\_\_ Credit card number      \_\_\_\_\_ Expiry date      \_\_\_\_\_ Cardholder Name as it appears on the card

**Banking Authorization**

I/We authorize Maritime Life to debit My/Our bank account for premiums due for insurance applied for on this application. The pre-authorized monthly payment plan will terminate if the financial institution does not honour the payment. The pre-authorized monthly method of payment may be cancelled or changed by providing 30 days written notice to Maritime Life. This authorization shall continue to have effect so long as I/We maintain insurance coverage with Maritime Life. **OR** I authorize the premium due to be remitted to Maritime Life through my credit card account.

Signature of Account Depositor \_\_\_\_\_ Date \_\_\_\_\_ (dd/mm/yy)

Signature of Joint Account Depositor \_\_\_\_\_ Date \_\_\_\_\_ (dd/mm/yy)  
(if applicable)

Signature of Cardholder \_\_\_\_\_ Date \_\_\_\_\_ (dd/mm/yy)

**6. AGREEMENTS & AUTHORIZATIONS**

**Confidentiality Agreement**

In order to ensure the confidentiality of the personal information held concerning you, we will establish an insurance file in which the information concerning your application will be placed, as well as information concerning any claim. Only authorized employees or authorized organizations will have access to this file. Your file will be kept in the company's offices. Personal information in the file will be made available to you and, if applicable, have it rectified by submitting a written request to the following address: The Maritime Life Assurance Company, Sponsored Markets, PO BOX 4606 STN A, TORONTO, ON M5W 4Z2

**Declarations**

I/We declare that the statements made on this Application are true and complete and form part of any certificate/policy issued. I/We agree that acceptance of any certificate/policy issued constitutes approval of the provisions of the certificate/policy and ratification of any additions, endorsements or amendments. I/We am/are aware that the certificate/policy issued contains specific restrictions with regard to the survival period, moratorium and any pre-existing conditions. I/We agree that any certificate/policy issued takes effect the 1<sup>st</sup> of the month following approval, delivery and full payment of the first premium and then only if there has been no change in My/Our insurability, subsequent to the completion of this Application.

The foregoing authorizations are valid during initial underwriting, the contestability period and for any claim that arises. A photographic copy of these signed Authorizations is as valid as the original.

**INSURANCE IS A CONTRACT BASED ON TRUST. FAILURE TO FULLY DISCLOSE FACTS MATERIAL TO THIS APPLICATION CAN RENDER THE CONTRACT VOID.**

Signed in the City of \_\_\_\_\_, and Province of \_\_\_\_\_

Signature of Member \_\_\_\_\_ Date \_\_\_\_\_ (dd/mm/yy)

Signature of Spouse (if applying) \_\_\_\_\_ Date \_\_\_\_\_ (dd/mm/yy)

**Remember to complete both sides.**