

CRITICAL ILLNESS INSURANCE APPLICATION FORM

Please print answers to all questions in ink.

APPLICANT INFORMATION

Applicant

Title _____ Last Name _____ First Name _____ Middle Initial _____
 Date of Birth _____ (DD/MM/YY) Gender Male Female PAS Membership # _____

Mailing Address

Please enter a mailing address:

Home Address _____
 City _____ Province _____ Postal Code _____ Telephone _____
 E-mail _____

HEALTH QUESTIONNAIRE

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Within the past 3 years, have you used any form of tobacco, marijuana, nicotine products or nicotine substitutes? | <input type="checkbox"/> | <input type="checkbox"/> |
| If you answer "Yes" to any of the following questions, you will not be eligible for coverage. | | |
| 2. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Cancer/malignancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Advanced ophthalmic disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Multiple sclerosis or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) AIDS, HIV, chronic or unexplained infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the last five years have you ever had, been diagnosed with or had any known indication of a medical problem with respect to the following: | | |
| a) Untreated or uncontrolled high blood pressure, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of, a cardiac event? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Diabetes, digestive or intestinal disorder, excluding functional disorders e.g. Irritable Bowel Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Hospitalization due to a medical problem with respect to severe respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Used habit forming drugs, or received treatment or medical advice due to the use of drugs or alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been declined for life insurance or offered coverage at higher than standard rates? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever sought advice or received treatment for, or had any known indication of: | | |
| a) Advanced loss of hearing? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does your height and weight fall outside the chart noted below? | <input type="checkbox"/> | <input type="checkbox"/> |

Males						Females					
Height	Min Weight (lbs)	Max Weight (lbs)	Height	Min Weight (lbs)	Max Weight (lbs)	Height	Min Weight (lbs)	Max Weight (lbs)	Height	Min Weight (lbs)	Max Weight (lbs)
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

PLAN AND COVERAGE

Coverage is available in units of \$25,000 with a maximum \$100,000. First year premiums are based on your age, sex and smoking status at the time you apply (please see Premium Table). Renewal premiums will increase according to your attained age on the first of the month coincident with or following the date you enter the next age band. Coverage terminates at age 70.

Please select the amount of coverage you require: \$25,000 \$50,000 \$75,000 \$100,000

PRE-AUTHORIZED DEBIT (PAD) (Attach a void cheque)

I have attached a void cheque.

I authorize Johnstone's Insurance Services Inc. and the financial institution designated to begin deduction of premium for the Critical Illness Insurance Plan in the amount of \$ _____ (Your monthly premium) to be charged on or about the first business day of each month to the account shown on the attached void cheque.

Signature: _____

Date: _____

Signature: _____

Date: _____

Secondary signature required on joint account.

I have waived the right to pre-notification at least 10 days before my first PAD; however Johnstone's Insurance Services Inc. will send me written notice identifying the new amount at least 10 days before each and any change in the amount of my PAD, with the exception of a reduction in tax rate. I may revoke my authorization at any time in writing or by phone, subject to a 30 day notice. To obtain a sample cancellation form or for information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca. I have certain recourse rights if any PAD does not comply with this agreement. For example, I 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 my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

DECLARATION & AUTHORIZATION

When you apply for coverage under the Critical Illness Insurance Plan ("Plan"), underwritten by ACE INA Life Insurance ("ACE Life"), the information in ACE Life's existing insurance files and the information requested in connection with your application is required by ACE Life, its reinsurers and authorized agents to process your application, and if approved, administer your insurance policy, assess coverage and claims. ACE Life will create a file with your information, and in the event of a claim, with such information as ACE Life obtains from you and other sources, for the purpose of considering your claim and administering benefits under the Plan. Access to this file will be restricted to those ACE Life employees, authorized agents and reinsurers who require access to administer the Plan and process claims and other persons where authorized by law. You may request to review your personal information in this file or request to make a correction by writing to: The Privacy Officer; ACE INA Life Insurance, 1400 - 25 York Street, Toronto, ON M5J 2V5. For more information on privacy at ACE visit www.ace-ina.com/privacy. From time to time there may be additional or enhanced ACE Life products or services available to you. The use of your personal information for the purposes of offering you such additional or enhanced products or services is entirely optional. If you do not wish your personal information to be used by ACE Life for this optional purpose, please tick here:

AUTHORIZATION FOR USE OF YOUR PERSONAL INFORMATION & PRIVACY NOTICE

DECLARATION: *I hereby declare that the above answers and statements are complete and true and I understand that concealment, misrepresentation or false declaration concerning this application will cause any policy to be void. I understand and agree that any coverage issued as a result of this application shall not take effect until this application is approved by ACE INA Life Insurance.*

AUTHORIZATION: *I hereby apply for the Critical Illness Insurance Plan. I have read and understand the terms of this application, including the Privacy Notice & Authorization for Use of Personal Information. I understand that my coverage will not take effect until the first day of the month following the month in which ACE INA Life Insurance (ACE Life) processes my Application Form of which I will be notified. I further have read and understand the features, limitations and exclusions of the Critical Illness Insurance Plan. I authorize my premiums to be debited to the bank account number indicated.*

Signed at _____ this _____ day of _____ 20 _____

Applicant's Signature _____

Applicant's Name (Please Print) _____

Please return your completed Application To:

Lothman Insurance and Consulting ;
134 Primrose Drive
The Mall at Lawson Heights
Saskatoon, SK S7K 5S6