



CAPRI OPTIONAL CRITICAL ILLNESS CLIENT APPLICATION

PLEASE PRINT

For Office Use Only

Policy# _____	Client # _____
	Spouse # _____

CLIENT INFORMATION

Last Name	<input type="text"/>	Birthdate	<input type="text"/>
			(DD/MM/YY)
First Name	<input type="text"/>	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Smoking Status	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker
	<input type="checkbox"/> Divorced <input type="checkbox"/> Common law (cohabited for at least 12 months)	Language Preference	<input type="checkbox"/> English <input type="checkbox"/> French
Home Address	<input type="text"/>		
City	<input type="text"/>	Province	<input type="text"/>
		Postal Code	<input type="text"/>
Email Address:	<input type="text"/>		

SPOUSAL INFORMATION

Last Name	<input type="text"/>	Birthdate	<input type="text"/>
			(DD/MM/YY)
First Name	<input type="text"/>	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
		Smoking Status	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker

DEPENDENT INFORMATION

Last Name	First Name	Birthdate (DD/MM/YY)	Gender M/F	Full-time Student (age 21-25)	Disabled Dependent (over age 21)
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

BENEFICIARY DESIGNATION

I hereby name the following revocable beneficiary (Irrevocable in the province of Quebec) for any Critical Illness Insurance benefits payable as a result of my participation in 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 under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the trustee to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

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 the box below:

I hereby make the beneficiary designated below:

Revocable, I may elect to change this beneficiary designation at any time.

Beneficiary's Full Name _____ Relationship to You _____

Trustee's Name (if applicable) _____

BENEFIT AMOUNT SELECTION

A

Optional Critical Illness

	Guaranteed Issue	Evidence of Insurability**
<input type="checkbox"/> Client Coverage	\$ _____	\$ _____ <input type="checkbox"/> Smoker or <input type="checkbox"/> Non-Smoker
<input type="checkbox"/> Spousal Coverage	\$ _____	\$ _____ <input type="checkbox"/> Smoker or <input type="checkbox"/> Non-Smoker
<input type="checkbox"/> Dependent Children *	\$5,000 or \$10,000	- please circle only one if you are adding coverage for your child

(Only available in conjunction with the enrollment of the client and/or spouse)

****WILL REQUIRE COMPLETION OF THE GROUP CRITICAL ILLNESS STATEMENT OF HEALTH**

Privacy Statement: When you apply to enroll in the Group Insurance Plan, underwritten by ACE INA Life Insurance ("ACE Life"), the information in ACE Life's existing insurance files and the information requested on your application is required by ACE Life, its reinsurers and authorized agents to process your application (*and if approved*), administer your insurance policy, assess claims and investigate misrepresentation. ACE Life will create a file with your insurance 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 persons 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.

I hereby apply for coverage under the Group Life Insurance Plan, underwritten by ACE INA Life Insurance, for which I am or may become eligible and authorize any required payroll deductions for administration of my benefits. I certify that the information provided herein is true, accurate and complete; and that I have no other coverage under this plan and have not applied for any.

PLEASE SIGN HERE 

Client's Signature _____

Date (DD/MM/YY) _____



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PAYMENT AUTHORIZATION FORM

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

I have attached a void cheque. These services are for (check one): Personal use Business use

I authorize ACE INA Life Insurance and the financial institution designated to begin deduction of premium for Optional Critical Illness 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 ACE INA Life insurance 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 debit 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.

CREDIT CARD

I authorize premiums for OPTIONAL CRITICAL ILLNESS to be charged to the following account:

(CIRCLE ONE) **VISA** **MASTERCARD**

Account #: _____

Expiry: _____

Signature: _____

Date: _____

Please submit this form by mailing to:

**Suite 100-1500 Hardy Place
Kelowna, BC
V1Y 8H2**

Or Fax:

250-860-1213

Or scan and Email:

ci@capri.ca

