cupw•sttp

www.coughlin.ca/cupw

Sun Life

This coverage is underwritten by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Application Form
FREE Basic Life Insurance Coverage

Side A

Policy #: 87032G

1 MEMBER INFORMATION

LAST NAME	FIRST NAME		INITIAL
DATE OF BIRTH (yyyy/mm/dd) / CUPW IDENTIFICATION NUMBER (Mandatory)		LANGUAGE ☐ English ☐ French	SEX ☐ Male ☐ Female
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE
TELEPHONE (Home) / TELEPHONE (Cell)	EMAIL ADDRESS		

2 BENEFICIARY DESIGNATION

LAST NAME	FIRST NAME	INITIAL
DATE OF BIRTH (yyyy/mm/dd) / RELATIONSHIP TO PLAN MEMBER		%
LAST NAME	FIRST NAME	INITIAL
DATE OF BIRTH (yyyy/mm/dd) / RELATIONSHIP TO PLAN MEMBER		%
LAST NAME	FIRST NAME	INITIAL
DATE OF BIRTH (yyyy/mm/dd) / RELATIONSHIP TO PLAN MEMBER		%

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box.

☐ REVOCABLE BENEFICIARY

If you do not nominate a beneficiary, the proceeds will be paid to your estate.

This beneficiary declaration will supercede all previous nominations and will apply to both Basic Life Insurance and Optional Life Insurance policies issued by Sun Life on behalf of CUPW.

3 SPOUSAL INFORMATION (IF APPLICABLE)

LAST NAME	FIRST NAME	INITIAL
DATE OF BIRTH (yyyy/mm/dd)	SEX ☐ Male ☐ Female	

4 COVERAGE FOR CHILDREN

CHILD'S NAME (Last, First)	DATE OF BIRTH (yyyy/mm/dd)
CHILD'S NAME (Last, First)	DATE OF BIRTH (yyyy/mm/dd)
CHILD'S NAME (Last, First)	DATE OF BIRTH (yyyy/mm/dd)
CHILD'S NAME (Last, First)	DATE OF BIRTH (yyyy/mm/dd)

5 AGREEMENT AND AUTHORIZATION TO COLLECT, USE, AND DISCLOSE PERSONAL INFORMATION

Agreement and Authorization. By signing this form:
1. You are applying for coverage under the plan sponsor's group insurance plan ("Plan"), and you authorize the required deductions from your salary or wages for any contribution you must make toward the cost of the benefits for which you are enrolled, if any, in accordance with the provisions of the Plan.
2. You authorize us, Coughlin & Associates Ltd. ("Plan Administrator"), a People Corporation company, to use and disclose the information you provide in this form as described below. You also agree to notify us immediately of any changes to the information you provide in this form.
3. You certify that the information you have provided is true, correct, and complete to the best of your knowledge and you certify that, if you have provided information about a spouse, dependant child, beneficiary, or trustee, you are authorized to provide such information and have obtained such consents as are required for us to use and disclose such information as set out herein. You agree that a photocopy or electronic copy of your signed form is as valid as the original.

Use of personal information.
1. We use and disclose your plan member information to:
(a) Determine your, your spouse's, and your dependant children's eligibility for benefits under the Plan, arrange for your benefits under the Plan, administer the Plan and your participation in the Plan, audit, manage, and assess the Plan and your benefit claims, investigate your claims, pay benefits to you, and comply with regulatory requirements, and for analytical purposes.
(b) Verify your identity and conduct searches to locate you, or your beneficiaries.
(c) Respond to questions about the Plan and benefits under the Plan.
2. We use and disclose personal information and, if applicable, personal health information for actuarial valuation of the Plan and benefits, to determine eligibility of dependant children for benefits, and when necessary to verify identity.

If you are required to participate in the Plan, you may not withdraw your consent for this use and disclosure of personal information for mandatory benefits. If you withdraw your consent for any optional benefits, then you may no longer be enrolled for those benefits.

Use of optional personal information. If you provide any of the information described below, you may withdraw your consent for us to use and disclose this information by sending your request in writing to the Plan Administrator or our Privacy Officer using the contact information below.
1. If you provide beneficiary information, any benefits paid on your death that are not required to be paid to your spouse, will be paid to the specified beneficiaries. If you do not provide the beneficiary information, the death benefits will be paid to your estate.
2. If you designate a beneficiary who is under the age of 18, and this beneficiary becomes entitled to receive a benefit under the Plan upon your death, then we will pay this benefit in trust to the trustee you identify.
3. If you provide your banking information as related to any optional life insurance coverage, such information will be used to pay for the premiums associated with such coverage.

Disclosing personal information. The information provided in this form may be disclosed, when necessary, to:
1. Our and our affiliates' employees, contractors, and professional advisors who require the information to perform their duties related to the uses of personal information described above.
2. Service providers we retain to assist us with our obligations related to the Plan, which may include security of information, data processing, claim processing, fraud monitoring, backup and programming, mailing, and people locating. Service providers may be located within or outside of Canada and the information may be subject to disclosure to government authorities.
3. Persons you authorize to access this information.
4. Persons legally authorized to view this information.
5. The financial institution(s) related to your banking information, government agencies, actuaries, insurance companies and their reinsurers and service providers, your employer, Plan trustees and union, and auditors.

Optional Communications

☐ By checking this box, you consent to receive electronic communications about our other products and services or products and services of our affiliates and service providers.

Member signature (for **CUPW Basic Life Insurance** coverage)

Date (yyyy/mm/dd)

COUGHLIN
employee benefits specialists

Protecting your personal information. We recognize and respect your right to privacy. When personal information is provided to us, we establish a confidential file that is kept in our facilities or in the facilities of an organization that we authorize. We limit access to information in your file to our personnel or other persons we authorize, who require the information to perform their duties with respect to the Plan, to persons to whom you have granted access, and to persons authorized by law. If you require more detail about how we protect your personal information or the other persons to whom we disclose your personal information, you may access our Privacy Policy at https://www.peoplecorporation.com/privacy/ or contact our privacy officer by mail sent to Coughlin & Associates Ltd., 1403 Kenaston Blvd., Winnipeg, MB, R3P 2T5, or by email sent to privacy.officer@peoplecorporation.com.

Complete application on reverse for CUPW Optional Life Insurance coverage

Now with Critical Illness Insurance included. For more information on the Critical Illness coverage, please visit https://coughlin.ca/clients/cupw/pdf/NeedToKnow_CriticalIllness_ENG.pdf

P.O. Box 3517, Station C, Ottawa, ON K1Y 4H5 | tel. 613-231-4433 | 1-888-304-2894

Application Form
OPTIONAL Life Insurance Coverage

Side B

FREE $5,000 Critical Illness Insurance included if member and/or spouse is approved for Optional Life Insurance

Policy 87032G (Optional Life) and 106732 (Critical Illness)

6 In addition to the free basic insurance, please enroll me in the optional term life and AD&D plan for the amount indicated in the box below*:

Optional Coverage for Member

☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $175,000 ☐ $200,000 ☐ $225,000 ☐ $250,000

Optional Coverage for Spouse

☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $175,000 ☐ $200,000 ☐ $225,000 ☐ $250,000

Optional Coverage for Eligible Children

☐ **$10,000** I apply for coverage on my child(ren) in the amount of $10,000 for each child and attest that they are in good health. An eligible child is over the age of 14 days but under the age of 21 years of age; or at least 21 years of age but less than 25 years of age if full-time student. The total cost of life and accidental death & dismemberment coverage for children is $2 per month per family.

**Optional coverage is subject to an additional premium. The maximum life insurance coverage at age 65 is $150,000 and terminates on the 1st of January following the insured's 70th birthday.*

7 MEDICAL QUESTIONNAIRE (REQUIRED IF APPLYING FOR OPTIONAL COVERAGE)

MEMBER HEIGHT	MEMBER WEIGHT	SPOUSE HEIGHT	SPOUSE WEIGHT
☐ ft./in. ☐ cm	☐ lbs. ☐ kg	☐ ft./in. ☐ cm	☐ lbs. ☐ kg

If you answer "Yes" to any of the questions below: Provide further details using a separate sheet of paper, ensuring all are signed, dated and stapled to this form. Do not tell us about genetic testing or genetic test results.

	MEMBER	SPOUSE
1. Have you used tobacco products in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you ever: a) been admitted to a hospital or clinic as a patient (except for pregnancy or birth) for longer than five consequative days?	☐ Yes ☐ No	☐ Yes ☐ No
b) received disability benefits for three months or longer?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you ever had an application for life or disability insurance declined or assessed at a rate higher than a standard premium rate?	☐ Yes ☐ No	☐ Yes ☐ No

4. Have you ever: a) received any treatment for (including taking pills, injections or other medications); or b) consulted a physician; or c) been diagnosed as having:

	MEMBER	SPOUSE		MEMBER	SPOUSE
Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)	☐ Yes ☐ No	☐ Yes ☐ No	Kidney disorder	☐ Yes ☐ No	☐ Yes ☐ No
Any test indicating the presence of the HIV (AIDS) virus	☐ Yes ☐ No	☐ Yes ☐ No	Psychiatric or psychological problems	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	Lung and/or respiratory disorder	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	Neurological disorder	☐ Yes ☐ No	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	☐ Yes ☐ No	Digestive disorder	☐ Yes ☐ No	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	☐ Yes ☐ No	Chronic Fatigue Syndrome	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No	Alcohol or drug abuse	☐ Yes ☐ No	☐ Yes ☐ No
Liver disorder	☐ Yes ☐ No	☐ Yes ☐ No	Arthritis or back problems	☐ Yes ☐ No	☐ Yes ☐ No

If "yes" to any answer, please provide details:

Member

Spouse

***MONTHLY PREMIUM RATES (per $25,000 of coverage)**

Age	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker
Under age 40	$2.30	$4.40	$1.95	$3.65
40 to 44	$3.35	$7.25	$3.35	$5.10
45 to 49	$6.55	$13.20	$5.85	$9.35
50 to 54	$11.50	$23.05	$9.35	$15.35
55 to 59	$21.00	$38.75	$14.95	$23.10
60 to 64	$30.50	$53.15	$19.85	$29.70
65 to 69	$44.68	$87.23	$28.40	$46.20

Example: A 38-year-old male, non-smoker could recieve $100,000 of insurance protection (4 x $25,000) for $9.20 (4 x $2.30) per month. **Premiums are re-calculated each January 1, based on your age and smoker status.**

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2. You authorize us, Coughlin & Associates Ltd. ("Plan Administrator"), a People Corporation company, to use and disclose the information you provide in this form as described below. You also agree to notify us immediately of any changes to the information you provide in this form.
3. You certify that the information you have provided is true, correct, and complete to the best of your knowledge and you certify that, if you have provided information about a spouse, dependant child, beneficiary, or trustee, you are authorized to provide such information and have obtained such consents as are required for us to use and disclose such information as set out herein. You agree that a photocopy or electronic copy of your signed form is as valid as the original.

Use of personal information.
1. We use and disclose your plan member information to:
(a) Determine your, your spouse's, and your dependant children's eligibility for benefits under the Plan, arrange for your benefits under the Plan, administer the Plan and your participation in the Plan, audit, manage, and assess the Plan and your benefit claims, investigate your claims, pay benefits to you, and comply with regulatory requirements, and for analytical purposes.
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5. The financial institution(s) related to your banking information, government agencies, actuaries, insurance companies and their reinsurers and service providers, your employer, Plan trustees and union, and auditors.

Optional Communications

☐ By checking this box, you consent to receive electronic communications about our other products and services or products and services of our affiliates and service providers.

I certify or confirm that I am actively at work and a member in good standing with CUPW on the date this application is signed.

Member signature (for **CUPW Optional Life Insurance** coverage) _____ **Date** (yyyy/mm/dd) _____

Spouse signature (for **CUPW Optional Life Insurance** coverage) _____ **Date** (yyyy/mm/dd) _____

Protecting your personal information. We recognize and respect your right to privacy. When personal information is provided to us, we establish a confidential file that is kept in our facilities or in the facilities of an organization that we authorize. We limit access to information in your file to our personnel or other persons we authorize, who require the information to perform their duties with respect to the Plan, to persons to whom you have granted access, and to persons authorized by law. If you require more detail about how we protect your personal information or the other persons to whom we disclose your personal information, you may access our Privacy Policy at https://www.peoplecorporation.com/privacy/ or contact our privacy officer by mail sent to Coughlin & Associates Ltd., 1403 Kenaston Blvd., Winnipeg, MB, R3P 2T5, or by email sent to privacy.officer@peoplecorporation.com.