CPCO BENEFITS PROGRAM APPLICATION FORM

General Information (please print clearly)

First Name	Initial	Last Name		Date of Birth (D/M/Y)	Gender ❑Female ❑ Male	CPCO Associate No:
Address		City	Province	Postal Code	Telephone Number	E-mail

Employment Information

School Board	Employee No.	Position	Affiliation: ❑ Elementary ❑ Secondary ❑ Other
Date of Appointment: (D/M/Y)	Annual Salary $	Name of School	Work e-mail
Work Address (i.e. School)	City	Province / Postal Code	Telephone Number / Ext.

Spousal Information (if applying for Life or AD&D only)

First Name	Initial	Last Name	Date of Birth (D/M/Y)	Gender ❑Female ❑ Male	

Long Term Disability (LTD)

Coverage:

❑ **Option 1** - 70% unreduced pension / No COLA

❑ **Option 2** - 70% unreduced pension / 3% COLA

❑ **Option 3** - 85 Factor / No COLA

❑ **Option 4** - 85 Factor / 3% COLA

Late Applicants: Applications made outside of the 90 day open enrolment period are considered late and are subject to insurer approval. Please complete the Evidence of Insurability Form available through Johnson along with this application. If approved, your effective date of coverage for LTD will be the date of approval.

❑ I have LTD coverage under an Individual or Group Policy insured by _____

❑ LTD coverage is not mandatory under the terms and conditions of employment at my board and I do not want LTD coverage.

You authorize your employer _____ to release information regarding your employment status including attendance records, salary information and job description to the CPCO Program Administrator, Johnson Inc., in order to allow for the administration of the Program and properly calculate premiums under the Program. This authorization allows Johnson Inc. to begin assisting you with the claims process as efficiently as possible. In the event that an LTD claim is filed, it will also serve to authorize Johnson Inc. to notify CPCO of your claim.

Signature

Signature: _____ Date: _____

Privacy Statement

Beginning January 1, 2004, the Personal Information Protection and Electronic Documents Act (PIPEDA) applied to personal information held by the insurance companies. In order to ensure the confidentiality of the personal information held concerning you, Johnson Inc. and/or Manulife Financial and/or Western Life Assurance Company will establish an insurance file in which the information concerning your application for insurance will be placed, as well as the information concerning any insurance claims. Only employees or authorized organizations who will be responsible for underwriting, administration, investigation and claims, or any other person you authorize, will have access to this file, and if applicable, to have it rectified by submitting a written request to the address listed below.

Contact Information

Please contact the Program Administrator if you have any questions.

Johnson Inc.	Phone	905.764.4959
1595 16th Avenue, Suite 100	Toll Free Phone	1.800.461.4155
Richmond Hill, Ontario	Fax	1.866.623.8257
L4B 3S5	e-mail	cpco@johnson.ca

PLEASE ENSURE YOU COMPLETE, SIGN AND DATE THE **REVERSE SIDE OF** THIS FORM.

Accidental Death and Dismemberment (AD&D)

Family Status Selected:

❑ Associate Only ❑ Family Coverage

❑ I do not want Accidental Death and Dismemberment

Amount of Coverage Selected:

❑ $200,000 ❑ $175,000 ❑ $150,000 ❑ $125,000

❑ $100,000 ❑ $75,000 ❑ $50,000 ❑ $25,000

If you have named a beneficiary under age 18, please indicate the name of the Trustee. Insurance cannot be paid to an under age beneficiary. All proceeds will be directed to the appointed legal guardian or trustee. To ensure underage beneficiaries are protected, please ensure that a legal guardian or trustee has been appointed through your Will.

Trustee:

Beneficiary Designation for Associate Coverage Note: The Associate is automatically the beneficiary for the spousal and children's AD&D insurance.

First Name	Last Name	Initial	Relationship to Associate

Life Insurance

Associate	Spouse	Coverage:
❑	❑	$200,000
❑	❑	$150,000
❑	❑	$100,000
❑	❑	$75,000
❑	❑	$50,000
❑	❑	$25,000
❑	❑	I do not want Life Insurance Coverage

Have you smoked cigarettes or cigarillos in the last 12 months?

Associate	Spouse	Indicate:
❑	❑	Yes
❑	❑	No

Yes: Smoker Rates Apply **No:** Non-Smoker Rates Apply

Children Coverage per Child:

❑ $20,000 ❑ $15,000 ❑ $10,000 ❑ $5,000

❑ I do not want Life Insurance for Dependent Children

Dependent Child(ren): Please provide Name and Date of Birth

1. 3.

2. 4.

Please Note: You must have selected either Life Insurance for yourself or your spouse to elect this coverage.

Beneficiary Designation for Associate Coverage Note: The Associate is automatically the beneficiary for the spousal and children's life insurance.

First Name	Last Name	Initial	Date of Birth (D/M/Y)	Relationship to Associate

For Residents of Quebec Only: A spousal beneficiary is irrevocable unless you make the designation revocable by checking here ❑ **Revocable**

If you have named a beneficiary under age 18, please indicate the name of the Trustee. Insurance cannot be paid to an underage beneficiary. All proceeds will be directed to the appointed legal guardian or trustee. To ensure underage beneficiaries are protected, please ensure that a legal guardian or trustee has been appointed through your Will.

Trustee:

Note: Amounts for Associate and Spouse above $50,000 require the completion of the Evidence of Insurability Form (available through Johnson) at all times, as do applications made beyond the 90 day open enrolment period.

It is important that the applicants smoking status be reported correctly. Misrepresentation will invalidate any claim that is made. Should your smoking status change in the future, please contact Johnson Inc.

Authorization

I understand that the insurance applied for shall become effective on the date specified by Manulife Financial and Western Life Assurance Company, only if this application is accepted and the first premium is paid. I hereby certify that the foregoing answers and statements are true and complete to the best of my knowledge and belief. I hereby apply for coverage under the CPCO Benefits Program. For premiums collected by bank deduction, I authorize the monthly deduction and remittance of premiums from my bank / trust company / credit union account for my contribution toward the cost of these benefits. For premiums collected by payroll deduction, I authorize my employer to deduct the required premium from my pay. The initial deduction may cover up to 3 monthly premiums. If more than one signature is required on cheques issued from a joint account, all depositors must sign below. I consent to the disclosure of any information required to administer the program. In the event of an LTD claim, I authorize Johnson Inc. to notify CPCO of said claim. I hereby certify that I am an associate in good standing of CPCO and that my eligibility under the CPCO Benefit Program ceases on termination of my affiliation with CPCO.

Applicant Signature _____ Date: _____

Signature of Joint Account Depositor (required for Joint Chequing) _____ Date: _____

Please attach a **VOID** cheque and return this application to Johnson Inc.