

CPCO BENEFITS PROGRAM APPLICATION FORM - Life and AD&D Insurance

General Information (please print clearly)						
First Name	Initial	Last Name	Date of Birth (D/M/Y)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	CPCO Associate No:	
Address		City	Province	Postal Code	Telephone Number	E-mail

Employment Information						
School Board	Employee No.	Position	Affiliation: <input type="checkbox"/> Elementary <input type="checkbox"/> Secondary <input type="checkbox"/> 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 <input type="checkbox"/> Female <input type="checkbox"/> Male	

Life Insurance							
Associate <input type="checkbox"/>	Spouse <input type="checkbox"/>	Coverage: \$200,000	Have you smoked cigarettes or cigarillos in the last 12 months? Yes: Smoker Rates Apply	Associate <input type="checkbox"/>	Spouse <input type="checkbox"/>	Indicate: Yes No No: Non-Smoker Rates Apply	Children Coverage per Child: <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> 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.
<input type="checkbox"/>	<input type="checkbox"/>	\$150,000		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	\$100,000		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	\$75,000		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	\$50,000		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	\$25,000		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	I do not want Life Insurance Coverage		<input type="checkbox"/>	<input type="checkbox"/>		

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 <input type="checkbox"/> 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.

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

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.

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: _____

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	cpc@johnson.ca



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