CPA INSURANCE PLANS WEST

Plans designed exclusively for CPAs.

Print Reset

A. This is a: ☐ First Application ☐ Application for additional insurance under Certificate No. _____ ☐ Request for transfer of insurance from Firm _____

B. (1) Application is for: ☐ Member ☐ Member Spouse ☐ Student ☐ Student Spouse
(2) Are you a Member / Student of CPA: (check) ☐ Yes: ☐ BC ☐ AB ☐ MB ☐ SK ☐ YK ☐ NT ☐ NU ☐ No
(3) If application is for insurance on a spouse, please provide name of Member / Student: _____
Note: You must be a member or student of a participating CPA body or the spouse of such member/student, to maintain eligibility for this insurance.

C. Complete if this is a first application. Insurance applying for:

	Amount of Insurance
Term Life	$ _____
Accidental Death and Dismemberment	$ _____
Member Long Term Disability Waiting Period (Days) ☐ 30 ☐ 90 ☐ 120 ☐ 180 ☐ 365	$ _____
Member Office Overhead	$ _____
Dependent children term life, AD&D: ☐ Yes	
Critical Illness	$ _____

D. Complete if application is for additional insurance or if a request for transfer.

	Present Amount of Insurance	Additional Amount Applying for	Total Amount of Insurance
Term Life	$ _____	$ _____	$ _____
Accidental Death or Dismemberment	$ _____	$ _____	$ _____
Member Long Term Disability	$ _____	$ _____	$ _____
Waiting Period (Days) ☐ 30 ☐ 90 ☐ 120 ☐ 180 ☐ 365			
Member Office Overhead	$ _____	$ _____	$ _____
Critical Illness	$ _____	$ _____	$ _____

E. To be completed in full. Please Print

(1) a) Name of Applicant _____
LAST FIRST SECOND

b) Residence Address _____

_____
CITY PROVINCE POSTAL CODE

c) Name of Employer _____

d) Employer Address _____

_____
CITY PROVINCE POSTAL CODE

g) Address to which correspondence is to be forwarded: ☐ Residence ☐ Business

e) Preferred email address _____

e) Your Occupation _____ Average Monthly Earnings $ _____

f) Residence Phone _____ Business Phone _____

(2) Birthday _____ (3) ☐ Male ☐ Female
MONTH / DAY / YEAR

(4) Beneficiary Designation (for Term Life or Accidental Death)
I hereby revoke all previous beneficiary designations and designate the following beneficiary(ies):

Beneficiary's name(s)			% Allocated	Relationship to Applicant
LAST NAME	FIRST NAME	MIDDLE INITIAL		
LAST NAME	FIRST NAME	MIDDLE INITIAL		
LAST NAME	FIRST NAME	MIDDLE INITIAL		

To be divided ☐ As per the percentages indicated above or, ☐ In equal shares to the survivors(s)
You may change this beneficiary designation at any time by notifying CPAIPW. If designating a beneficiary who is a minor or who lacks legal capacity, you must appoint a trustee/administrator. Please download the "Appointing a Trustee" Form from our website at www.cpaipw.ca.

Signature of Applicant _____ Date _____ Signature of Witness _____

9918A – 102 Street, Fort Saskatchewan, Alberta T8L 2C3 | Ph: 780.998.1798 | Fax: 780.997.6467 | Toll-Free: 1.800.661.6430 | info@cpaipw.ca

CPA INSURANCE PLANS WEST
Plans designed exclusively for CPAs.

A group insurance plan insured by Desjardins Financial Security and administered by CPA Insurance Plans West

Health and lifestyle questionnaire (Evidence of insurability)

GROUP INSURANCE

3 steps to follow after completing this questionnaire:

- Make a complete copy for your records
- Attach a copy of your insurance application to the questionnaire
- Return the original to the following address: CPA Insurance Plans West
  9918A–102 Street, Fort Saskatchewan AB T8L 2C3

A. Applicant

First name | Last name | Sex ☐F ☐M

Address - No., street, apt. | City | Province | Postal Code

Telephone numbers
Home (Area code + No.): | Work (Area code + No.):

Occupation:

This information is required to process your application.

Date of birth (yyyy - mm - dd) | Place of birth (province, state, country)

Are you presently working? ☐Yes ☐No | If so, number of hours worked each week – If you are not working, state reason

Height ☐ft in ☐cm | Weight ☐lb ☐kg | Weight one year ago ☐lb ☐kg

Reason for change in weight (if applicable)

B. Employer

Name and address of employer

C. Children

Child 1	Child 2	Child 3
First name / Last name	First name / Last name	First name / Last name
Sex ☐F ☐M / Date of birth (yyyy - mm - dd)	Sex ☐F ☐M / Date of birth (yyyy - mm - dd)	Sex ☐F ☐M / Date of birth (yyyy - mm - dd)
Height ☐ft in ☐cm / Weight ☐lb ☐kg	Height ☐ft in ☐cm / Weight ☐lb ☐kg	Height ☐ft in ☐cm / Weight ☐lb ☐kg
Weight one year ago ☐lb ☐kg	Weight one year ago ☐lb ☐kg	Weight one year ago ☐lb ☐kg
Reason for change in weight (if applicable)	Reason for change in weight (if applicable)	Reason for change in weight (if applicable)

D. Health questionnaire

		Applicant
1.	Are you currently being treated by a physician or another health care professional or taking any medication?	☐ Yes ☐ No
2.	Are you intending to consult a physician or another health care professional, or to undergo surgery?	☐ Yes ☐ No
3.	Have you ever suffered from an infirmity, a deformity or any other physical, nervous or mental disorder?	☐ Yes ☐ No
4.	Have you ever undergone an electrocardiogram, an X-ray, a mammography, a colonoscopy, a blood test or any other examination?	☐ Yes ☐ No
5.	Have you ever undergone or been advised to undergo laboratory tests for the detection of the AIDS virus or antibodies to the virus?	☐ Yes ☐ No
6.	Have you ever been prescribed a diet, medication, treatment or surgery?	☐ Yes ☐ No
7.	Have you ever been treated in a hospital, clinic or rehabilitation centre?	☐ Yes ☐ No
8.	Have you ever claimed or received benefits or been absent from work for more than 10 consecutive days because of an illness or accident?	☐ Yes ☐ No
9.	Have you ever received abnormal diagnostic test results?	☐ Yes ☐ No
10.	Have you ever experienced symptoms for which you have not yet consulted a health care professional?	☐ Yes ☐ No
11.	Have you ever consulted a physician or another health care professional for any physical or mental disorder not mentioned above?	☐ Yes ☐ No
12.	Have any of the **children to be insured** ever suffered from heart, lung, neurological or mental problems, cancer or diabetes or had an application for insurance rejected, rated, modified or deferred?	☐ Yes ☐ No

Complete the table below for each question to which you answered yes. Use an additional sheet if needed.

No.	First name	Nature of illnesses, surgery, accidents, consultations, examinations, treatments, medication, results	Date	Length of illness/ disability	Length of hospitalization (if applicable)	Name and address of physicians or hospitals
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	
			yyyy - mm - dd	☐ days ☐ months ☐ years	☐ days ☐ months ☐ years	

E. Lifestyle questionnaire

		Applicant
1.	In the last 10 years, have you had an application for insurance declined or modified, or approved with an exclusion or extra premium? If yes, indicate the reason and the dates:	☐ Yes ☐ No
2.	In the last 5 years, have you had your driver's license suspended or revoked? If yes, indicate the reason and the dates:	☐ Yes ☐ No
3.	In the last 12 months, have you used any form of tobacco, including e-cigarettes or other tobacco substitutes?	☐ Yes ☐ No
4.	Have you ever been treated for alcohol or substance abuse or been advised to decrease consumption of alcohol or drugs? If yes, indicate the reason and the dates:	☐ Yes ☐ No

		Applicant
5.	What is your weekly consumption or use of:	
	tobacco, e-cigarettes or other tobacco substitutes	
	alcoholic beverages	
	narcotics or drugs	

F. History – ⚠ Complete for each proposed insured

Is there any history in your family (father, mother, brothers, sisters) of heart disease, stroke, high cholesterol, high blood pressure, diabetes, kidney disease, multiple sclerosis, Huntington's chorea, polyposis coli, cancer, Alzheimer's disease, Parkinson's disease, muscular dystrophy, motor neuron diseases or other hereditary diseases?

☐ Yes ☐ No If Yes, please complete the table below. For cancer, indicate the type.

Check the family member					Illness(es) (if cancer: type)	Age at onset of the illness	Age if alive	Age at death
Applicant	Father	Mother	Brother	Sister				
	Father	Mother	Brother	Sister				
Children	Father	Mother	Brother	Sister				
	Father	Mother	Brother	Sister				

G. This section must be completed only when applying for the "critical illness" benefit

	Applicant
1. Have you ever had or been told you had, or been treated for:	
a. high blood pressure, heart attack, angina, chest pain, abnormal ECG, high cholesterol, heart murmur, peripheral vascular disease, dizziness, stroke, transient ischemic attack, or any other disorder of the heart, blood vessels or circulatory system?	☐ Yes ☐ No
b. cancer, tumours, polyps or any other growth, disease of the skin, blood, lymph node or any other type of malignancy?	☐ Yes ☐ No
c. diabetes, thyroid disorder, anemia, hepatitis or hepatitis carrier state or any other blood or glandular disorder?	☐ Yes ☐ No
d. disorder of the nose or throat, asthma, bronchitis, emphysema or any other chronic lung or respiratory disorder?	☐ Yes ☐ No
e. any disorder of the stomach, intestines, colon, rectum, liver or pancreas?	☐ Yes ☐ No
f. arthritis, any form of lupus or any disease of the bones, joints or muscles?	☐ Yes ☐ No
g. epilepsy, seizures, headaches, paralysis, coma, multiple sclerosis, tremors, Parkinson's disease, Alzheimer's, weakness of the muscles, muscular dystrophy, motor neuron disorder or any other neurological disorder?	☐ Yes ☐ No
h. anxiety, depression, chronic fatigue, or other mental or nervous disorder?	☐ Yes ☐ No
i. any disease or disorder of the kidney, bladder, prostate, breasts or genitourinary system?	☐ Yes ☐ No
j. AIDS, positive HIV test or any other immunological disorder or infection?	☐ Yes ☐ No
k. loss of speech or ear or eye disorders (excluding myopia or presbyopia)?	☐ Yes ☐ No
l. loss of hearing?	☐ Yes ☐ No

Complete the table below for each question to which you answered yes. Use an additional sheet if needed.

No.	First name	Nature of disorder	Date	Length of illness/ disability	Result	Name and address of physicians
			yyyy - mm - dd	☐ days ☐ months ☐ years		
			yyyy - mm - dd	☐ days ☐ months ☐ years		
			yyyy - mm - dd	☐ days ☐ months ☐ years		
			yyyy - mm - dd	☐ days ☐ months ☐ years		
			yyyy - mm - dd	☐ days ☐ months ☐ years		
			yyyy - mm - dd	☐ days ☐ months ☐ years		

H. Statement and authorization regarding your personal information

I hereby certify that the answers given above are complete and true and I agree that they form an integral part of my application for insurance. I hereby acknowledge that I have read the notice regarding personal information management, as well as the notice regarding the MIB, Inc. and that I have received a copy thereof. The insurance will become effective on the date indicated on the contract. Any false declaration may result in the cancellation of the insurance.

I authorize Desjardins Financial Security Life Assurance Company (DFS), its agents and service providers, including CPA Insurance Plans West (CPAIPW), to use and exchange relevant information on the present medical condition of any person to be insured (including confidential health information) for the purposes of determining insurability and managing the file.

For the sole purpose of determining insurability, managing files and processing claims, I also authorize DFS or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, Inc.

This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my application. A photocopy of this authorization is as valid as the original. If the Desjardins Financial Security Life Assurance Company medical director deems appropriate, I authorize him to send the information that he obtained to analyze my application or that supports the Company's decision to the following physician:

Name and address of physician: _____

Remember your signature and the date!

_____ Signature of applicant

_____ Date (yyyy - mm - dd)

_____ Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec)

I. Authorization regarding your personal information

I authorize Desjardins Financial Security Life Assurance Company (DFS), its agents and service providers, including CPA Insurance Plans West (CPAIPW), to use and exchange relevant information on the present medical condition of any person to be insured (including confidential health information) for the purposes of determining insurability and managing the file.

For the sole purpose of determining insurability, managing files and processing claims, I also authorize DFS or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, Inc.

This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my application. A photocopy of this authorization is as valid as the original.

Remember your signature and the date!

_____ Signature of applicant

_____ Date (yyyy - mm - dd)

_____ Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec)

Personal information management

CPA Insurance Plans West (CPAIPW) recognizes and respects the importance of privacy. When you apply for coverage, CPAIPW establishes a confidential file that is kept in its offices. CPAIPW limits access to personal information in your file to its staff or persons authorized by CPAIPW who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. CPAIPW uses the personal information to determine the insurability of any person to be insured and to administer the group benefits plan.

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. This information is consulted solely by DFS employees who need to do so in the course of their work. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2.

DFS may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at DFS.

DFS uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, personal information may be transferred to another country and be subject to the laws of that country. For information about DFS's policies and practices regarding the transfer of personal information outside of Canada, visit the DFS website at www.desjardinslifeinsurance.com or write to the DFS Privacy Officer at the address indicated above. The Privacy Officer can also answer any questions about the transfer of personal information to service providers located outside of Canada.

Notice applicable to MIB, inc.

Information regarding the insurability of the person to be insured will be treated as confidential by Desjardins Financial Security Life Assurance Company (DFS), its reinsurers and MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you submit an application for life or health insurance coverage for an individual or a benefit claim for an insured to another MIB, Inc. member company, upon request, MIB, Inc. will supply such company with the information it has on file about this person.

MIB, Inc. receives personal information for which the collection, use and disclosure is governed by the Personal Information Protection and Electronic Documents Act (PIPEDA) and provincial laws. Accordingly, MIB, Inc. has agreed to protect such information in a manner that is substantially similar to DFS's privacy and personal information protection practices and in accordance with applicable laws. As a U.S.-based company, MIB, Inc. is also bound by U.S. laws regarding the disclosure of personal information. If you have any questions about MIB, Inc.'s commitment to ensuring the confidentiality of insureds' personal information, contact the MIB, Inc. Privacy Department at privacy@mib.com.

Upon request, MIB, Inc. will disclose all of the information in an insured's file to that insured. Insureds can contact MIB, Inc. at 416 597-0590. Insureds who dispute the accuracy of the information MIB, Inc. has on record for them can seek a correction in accordance with the procedures set forth on MIB, Inc.'s Website at www.mib.com. They can also write to MIB, Inc.'s information office at 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7.

DFS and its reinsurers can also release information from their files to other insurance companies to which an application for life or health insurance or a benefit claim has been submitted. Consumers can obtain additional information about MIB, Inc. at www.mib.com.