CPA INSURANCE PLANS WEST

LIFE INSURANCE APPLICATION

TO ACCEPT $100,000 OF PREMIUM-FREE INSURANCE COVERAGE OFFER FOR ONE YEAR, PLEASE COMPLETE ALL SECTIONS BELOW:

1. Full Name: _________________________ 2. Date of Birth (M/D/Y):___________________________

2. Address: ____

City/Prov: _______________________ Postal Code: ________________________

3. CPA Member Province (please check applicable): ☐ **BC** ☐ **AB** ☐ **SK** ☐ **MB** ☐ **YK** ☐ **NT** ☐ **NU**

4. Phone Number: __________________________ Alternate Number: ___________________________

5. Email Address: _____________________________

6. Your Height: _______(inches) and Weight: _______(lbs)

7. Are you currently being treated by a physician or another health care professional or taking any medication? ☐ **Yes** ☐ **No**

8. Are you intending to consult a physician or another health care professional, or undergo surgery within the next 6 - 12 months? ☐ **Yes** ☐ **No**

9. Have you even been decline for any insurance? ☐ **Yes** ☐ **No**
(Should you answer yes to any of the above questions, a representative from our team will be in contact to discuss your options)

10. Name of Beneficiary: ____
(If a beneficiary has not been named, the benefit is paid to your estate. If your beneficiary is a minor, you must appoint a trustee. ***Originals of this form are required to legally bind your beneficiary designation****)*

Applicant Signature: ______________________________ Date: _______________________________

Witness Signature: ________________________________ Date: _______________________________

PLEASE MAIL THE ORIGINAL FORM TO:
CPA INSURANCE PLANS WEST
9918A 102 ST.
FORT SASKATCHEWAN, AB T8L 2C3

Or, visit www.cpaipw.ca to download and complete this application.
Note: For applications emailed, faxed or submitted online, coverage is conditionally approved pending receipt of an original signature, witnessed, for the beneficiary designation.

OFFER EXPIRES MARCH 31, 2019.