GROUP INSURANCE PLAN

CHUBB **VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT & CRITICAL ILLNESS HEALTH ENROLLMENT FORM**

IMPORTANT Note: Review all questions before completing; if you would answer "YES" to any of the questions on page 2, you are only eligible for the Guaranteed Issue amounts, and should only complete pages 1 and 3 of this form.

GROUP POLICY INFORMATION

Policyholder Name: Association of Ontario Midwives Benefits Trust	**Policy #: OE & CO 10443501**

PLAN MEMBER INFORMATION

Last Name:	**First Name:**	**Telephone #:**	
Date of Birth:	**Sex:** ☐ **F** ☐ **M**	**Preferered Pronouns:**	
Address:	**City:**	**Province:**	**Postal Code:**

SPOUSE OR PARTNER INFORMATION (Only to be completed if applying for Coverage)

Last Name:	**First Name:**	**Date of Birth:**	**Sex:** ☐ **F** ☐ **M**

DEPENDENT INFORMATION (Only to be completed if applying for Coverage)

	Last Name:	First Name:	Date of Birth:	Dependent Child (< age 21)	Full-Time Student (< age 25)	Disabled Dependent (> age 21)
Child				☐	☐	☐
Child				☐	☐	☐
Child				☐	☐	☐

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE SELECTION

	Plan Member	Spouse or Partner	Dependent Children
Benefit Amounts Selected	-	-	-
Monthly Premium (see Chart)			

The monthly premium rate is $0.015 per $1,000 of insurance
Member Only Plan – Choose amount from $10,000 to $250,000 in units of $10,000
Spouse or Partner Plan – Choose amount from $5,000 to $125,000 in units of $5,000
Children's Plan – Choose amount from $1,000 to $25,000 in units of $1,000

OPTIONAL CRITICAL ILLNESS COVERAGE SELECTION

	Plan Member	Spouse or Partner	Dependent Children*
Smoker Status	☐ Smoker or ☐ Non-Smoker	☐ Smoker or ☐ Non-Smoker	n/a
Benefit Amounts Selected	-	-	☐ $5,000 ☐ $10,000
Monthly Premium (see Calculator)			

**Child coverage only available in conjunction with the enrollment of the plan member and/or spouse/partner*
Guaranteed Issue - Up to $25,000, no medical required
Evidence of Insurability – Up to $150,000 per person combined with basic (plan members receive $10,000 basic coverage) and Guar-anteed Issue – **please complete Health Questionnaire on Page 2**

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** **HEALTH QUESTIONNAIRE FOR MEDICAL EVIDENCE COVERAGE ONLY** **

This Section of the form is **only to be completed** if applying for benefit levels higher than $25,000.

IMPORTANT Note: Review all questions before completing; if you would answer "YES" to any of the following questions you are only eligible for the Guaranteed Issue amounts, and should only complete pages 1 and 3 of this form.

	Plan Member		Spouse/Partner	
	Yes	No	Yes	No
1. Have you ever sought advice or received treatment for, or had any known indication of:				
a) Stroke (including transient ischemic attack), heart attack, coronary artery disease, severe valvular heart disease e.g. aortic stenosis, or any type of cardiac surgery?	☐	☐	☐	☐
b) Cancer, tumour or malignancy?	☐	☐	☐	☐
c) Advanced ophthalmic disease?	☐	☐	☐	☐
d) Multiple sclerosis or paralysis?	☐	☐	☐	☐
e) Any chronic or progressive disease or disorder of the kidney, lung, liver, pancreas or bone marrow that may lead to the failure of the organ or that may require transplantation?	☐	☐	☐	☐
f) AIDS, HIV, chronic or unexplained infections?	☐	☐	☐	☐
2. Within the last 5 years have you had; or been diagnosed with, or had any known indication of, a medical problem with respect to the following:				
a) Untreated or uncontrolled high blood pressure, angina, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of, a cardiac event?	☐	☐	☐	☐
b) Diabetes, digestive or intestinal disorder, excluding functional disorders e.g. Irritable Bowel Syndrome?	☐	☐	☐	☐
c) Hospitalized due to a medical problem with respect to severe respiratory disorder?	☐	☐	☐	☐
d) Used habit forming drugs, or received treatment or medical advice due to the use of drugs or alcohol?	☐	☐	☐	☐
3. Have you ever sought advice or received treatment for, or had any known indication of:				
a) Advanced loss of hearing?	☐	☐	☐	☐
b) Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorders?	☐	☐	☐	☐
c) any psychiatric disorder, mental deterioration or loss of intellectual ability?	☐	☐	☐	☐
d) Gout, Arthritis, Scleroderma, Muscular Dystrophy, Ataxia, Systemic Lupus Erythematosus, transverse myelitis, myasthenia gravis, post-polio syndrome, sarcoidosis or cystic fibrosis?	☐	☐	☐	☐
e) Amputation due to disease?	☐	☐	☐	☐
4. Do you currently:				
a) Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, oxygen, motorized cart or stair lift?	☐	☐	☐	☐
b) Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence?	☐	☐	☐	☐
c) Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?	☐	☐	☐	☐
5. Does your height and weight fall outside the chart noted below?	☐	☐	☐	☐

Males							Females					
Height	Min Weight	Max Weight	Height	Min Weight	Max Weight		Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4' 8"	95	145	5' 8"	132	207		4' 8"	86	145	5' 8"	119	207
4' 9"	98	150	5' 9"	137	213		4' 9"	88	150	5' 9"	123	213
4' 10"	100	155	5' 10"	141	219		4' 10"	90	155	5' 10"	127	219
4' 11"	103	160	5' 11"	145	225		4' 11"	93	160	5' 11"	131	225
5' 0"	105	165	6' 0"	150	233		5' 0"	95	165	6' 0"	135	233
5' 1"	108	170	6' 1"	155	241		5' 1"	97	170	6' 1"	140	241
5' 2"	111	175	6' 2"	160	249		5' 2"	100	175	6' 2"	144	249
5' 3"	114	180	6' 3"	165	257		5' 3"	103	180	6' 3"	149	257
5' 4"	118	185	6' 4"	170	265		5' 4"	106	185	6' 4"	153	265
5' 5"	121	190	6' 5"	175	272		5' 5"	109	190	6' 5"	158	272
5' 6"	124	195	6' 6"	180	279		5' 6"	112	195	6' 6"	162	279
5' 7"	128	201	6' 7"	185	285		5' 7"	115	201	6' 7"	167	285

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THIS APPLIES TO BOTH OPTIONAL CRITICAL ILLNESS AND VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE

BENEFICIARY DESIGNATION

All benefit payments, including benefits payable for any insured dependent child covered under this plan, if applicable are paid directly to you.

If you are deceased at the time that a benefit is payable, we will pay benefits to the beneficiary you named below. If you make changes to the beneficiary, we will pay the beneficiary named in your latest written change request. If you do not designate a beneficiary we will use the beneficiary designation made under the Policyholder's Group Life Insurance Policy. Failing such designation, all benefits will be paid to your Estate.

I hereby name the following revocable beneficiary (Irrevocable in the province of Quebec) for any Insurance benefits payable as a result of my participation in this plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid.

Please Note: In the province of Quebec, if you have designated your married or civil union spouse as beneficiary, the designation will be considered irrevocable unless you check here: ☐ Revocable.

I hereby make the beneficiary designation below; I may elect to change this beneficiary designation at any time.

Name of Beneficiary	Relationship to Insured	Percentage
		%
		%
		%

Complete this section if a beneficiary named on this form is a minor. If so, you agree that any benefit that becomes payable to a minor child will be paid to the trustee to hold in trust for the child until the child comes of age.

Name of Trustee	Relationship to Minor Beneficiary

I wish to appoint the following contingent beneficiary(ies) in the event my primary beneficiary predeceases me.

Name of Contingent Beneficiary	Relationship to Insured	Percentage
		%
		%

PRIVACY STATEMENT

At Chubb Life, we are committed to protecting our customers' privacy. Chubb Life's policy is to limit access to customer information to those who need it to serve customers' insurance needs and to maintain and improve customer service. The information provided by customers is required by us, our reinsurers and authorized administrators to assess customers' entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, we, our reinsurers and authorized administrators consult existing insurance files about customers, collect additional information about and from customers, and where required, collect information from and exchange information with, third parties. We do not disclose customer information to third parties other than our agents and brokers, except as necessary to conduct business, e.g., processing claims or as required by law. We advise customers that, in some instances, employees, service providers, agents, reinsurers, and any of their providers, of Chubb and/or Chubb Life may be located in jurisdictions outside Canada and that customers' personal information may thus be subject to the laws of those foreign jurisdictions.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

AUTHORIZATION

I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb and/or Chubb Life, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Signed at _____ **this** _____ **day of** _____ **20** _____

_____ _____

Plan Member's Signature Spouse or Partner's Signature (if applicable)

Information about your insurability and your dependents insurability will be treated as confidential.