CPA INSURANCE PLANS WEST APPLICATION FOR INDIVIDUAL COVERAGE

Please send a copy of the completed form to CPAIPW at 102-15511 123 Ave, Edmonton, Alberta T5V 0C3 or email a copy to info@cpaipw.ca.
Ensure to keep a copy for your personal record.

Certificate Number (For CPAIPW Head Office Use Only): _____

Section A. Personal Information

! This information is required to process your application.

Surname: _____ Given Name: _____ Phone Number (Preferred): _____

Phone Number (Alternative): _____ E-mail: _____

Date of Birth: Month _____ Day _____ Year _____ Gender: Male ☐ Female ☐

Application Status: CPA Member ☐ CPA Student ☐ Spouse of Member/Student ☐ CPA Number _____

Address of Correspondance: _____

City: _____ Province: _____ Postal Code: _____ Smoking Status: Smoker ☐ Non-Smoker ☐

How did you hear about us? Magazine Ad ☐ LinkedIn Ad ☐ Google Ad ☐
Sponsorship/Conference ☐ Referral ☐ Other ☐

Section B. New Member Coverage

! This information is required for new individuals joining our plan.

Term Life: Amount (Maximum of $2 Million): _____

Accidental Death and Dismemberment: Amount (Maximum of $2 Million): _____

Equivalent to term life on our plan or $1M ($500k for spouses), whichever is less.

Long Term Disability: (CPA Member Only) Average Monthly Earnings (Before Tax): _____

Amount: _____

Coverage at 60% on the 1st $11,668 of monthly earnings & 50% of earnings thereafter. Maximum $10k/month.

Waiting Period: 30 90 120 180 365

Office Overhead: (CPA Member Only) Amount (Maximum of $6,000): _____

Dependent Childrent Term Life / AD&D Amount: $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐

Critical Illness: Amount (Maximum of $250,000): _____

Child Critical Illness: Amount (Flat Benefit $10,000): Yes ☐ No ☐

Section C. Existing Member Coverage

! This information is required for current individuals under our plan.

Certificate Number: _____

	Current Coverage	Additional Amount	Total Amount
Term Life:			
Accidental Death and Dismemberment:			
Long Term Disability: (CPA Member Only)			

Waiting Period: 30 90 120 180 365

Office Overhead:					
Dependent Children Term Life/AD&D:	Amount: $10,000 ☐	$15,000 ☐	$20,000 ☐	$25,000 ☐	
Critical Illness:					
Child Critical Illness:	Amount (Flat Benefit $10,000): Yes ☐ No ☐				

Section D. Beneficiary Coverage

! This information is required to process your application.

Beneficiary Names(s) | **Percent Allocated** | **Relationship to Insured**

Last Name: _____ First Name: _____ Middle Initial: _____ _____ % _____

Last Name: _____ First Name: _____ Middle Initial: _____ _____ % _____

Last Name: _____ First Name: _____ Middle Initial: _____ _____ % _____

To Be Divided as Follows: As Per the Percentage Indicated Above ☐ **or** In Equal Shares to Survivor(s) ☐

Trustee Name (To Be Completed if You Are Designating a Child Under Age 18):

Last Name: _____ First Name: _____ Middile Initial: _____ Relationship to Insured: _____

Section E. Dependent Information

! This information is required for Dependent Child Term Life, AD&D and Child Critical Illness.

Dependent Names(s) | **Gender** | **Date of Birth (yyyy/mm/dd)**

Last Name: _____ First Name: _____ Middle Initial: _____ Male ☐ Female ☐ _____

Last Name: _____ First Name: _____ Middle Initial: _____ Male ☐ Female ☐ _____

Last Name: _____ First Name: _____ Middle Initial: _____ Male ☐ Female ☐ _____

Section F. Commitment to Privacy

Protecting Your Personal Information

At CPA Insurance Plans West, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the office of CPA Insurance Plans West or the offices of an organization authorized by CPA Insurance Plans West. We are committed to meeting or exceeding the privacy standard established by federal and provincial legislations and industry bodies.

The employees of CPA Insurance Plans West play an important role in protecting personal information. Our employees are required to adhere to this policy and take all reasonable steps to ensure that personal information is protected. The personal information that is collected is used to administer an individual's participation in the Plan and to pay benefits as defined by the Plan.

In administering an individual's participation in the Plan, personal information may also be collected from, or disclosed to, insurance companies or other companies that insure the benefits or provide administration and claims handling services; licensed physicians or other healthcare professionals or institutions; and government or regulatory authorities.

We only keep personal information for as long as is necessary for the purpose outlined previously in this policy. We are also required by law to maintain certain information for set periods of time. We have appropriate safeguards in place to protect personal information and when we no longer need the information, it is destroyed.

Section G. Authorization and Declaration

I have read and understand and agree with the contents of the section titled "Protecting Your Personal Information".

I hereby authorize: CPA Insurance Plans West, insurance companies or reinsurance companies, healthcare providers, administrators of government benefits or other benefit programs, other organizations or service providers working with CPA Insurance Plans West or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Insured Signature : _____ Date: _____

Witness Signature: _____ Date: _____

CPA INSURANCE PLANS WEST

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

GROUP INSURANCE

HEALTH AND LIFESTYLE QUESTIONNAIRE

EVIDENCE OF INSURABILITY

Completing the questionnaire

- Answer all questions.
- Provide information only for the proposed insured person(s).
- The proposed insured person(s) must read, physically sign and date the questionnaire.

After completing the questionnaire

- Keep a copy for your records.
- Attach a copy of your insurance application.
- Send the questionnaire and your insurance application to:

CPAIPW
102-15511 123 Ave, Edmonton, AB T5V 0C3

A IDENTIFICATION OF APPLICANT

This information is required to process your application.

Last name and first name

Sex ☐ M ☐ F

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

Telephone numbers

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

Occupation:

Date of birth | Place of birth (province, state, country)

Are you presently working? ☐ Yes ☐ No

If so, number of hours worked - If not, state reason:

Height	Weight	Weight one year ago	Reason for change in weight (if applicable)
☐ Ft in ☐ M	☐ Lb ☐ Kg	☐ Lb ☐ Kg	

B IDENTIFICATION OF EMPLOYER

Name

Address - No., street, office | City | Province | Postal code

C IDENTIFICATION OF PROPOSED INSUREDS

1 CHILD Last name and first name | Sex ☐ M ☐ F | Date of birth YYYY MM DD | Height ☐ Ft in ☐ M | Weight ☐ Lb ☐ Kg | Weight one year ago ☐ Lb ☐ Kg

Reason for change in weight (if applicable):

2 CHILD Last name and first name | Sex ☐ M ☐ F | Date of birth YYYY MM DD | Height ☐ Ft in ☐ M | Weight ☐ Lb ☐ Kg | Weight one year ago ☐ Lb ☐ Kg

Reason for change in weight (if applicable):

3 CHILD Last name and first name | Sex ☐ M ☐ F | Date of birth YYYY MM DD | Height ☐ Ft in ☐ M | Weight ☐ Lb ☐ Kg | Weight one year ago ☐ Lb ☐ Kg

Reason for change in weight (if applicable):

D HEALTH QUESTIONNAIRE

⚠ **COMPLETE FOR EACH PROPOSED INSURED.**

		APPLICANT		CHILDREN	
		Yes	No	Yes	No
1	In the **last 2 years**, has the proposed insured taken medication (not including contraceptives, vitamins and natural products) prescribed by a doctor for **more than 4 consecutive weeks**?	☐	☐	☐	☐
2	Has the proposed insured had or do they currently have discomfort, signs or symptoms for which:				
	• They have not yet consulted a doctor?	☐	☐	☐	☐
	• They are waiting to see a specialist?	☐	☐	☐	☐
	• They have consulted a doctor or other health professional and been advised to take medication, or undergo tests or surgery that has yet to happen or for which they are currently awaiting results?	☐	☐	☐	☐
3	In the **last 5 years**, has the proposed insured spent **more than 72 hours**:				
	• In a hospital, clinic or rehabilitation facility for care not related to pregnancy or childbirth?	☐	☐	☐	☐
	• In an alcohol, drug or gambling addiction treatment centre?	☐	☐	☐	☐
4	In the **last 5 years**, has the proposed insured been absent from work for health reasons other than maternity leave for **more than 4 consecutive weeks**?	☐	☐	☐	☐
5	**In the last 10 years**, has the proposed insured consulted a health professional, been diagnosed, received treatment or undergone surgery for any of the following:				
	• Abnormality of the immune system, including AIDS or a positive HIV test or other immunological infection or disorder	☐	☐	☐	☐
	• Cancer, tumor, polyp or other malignant disease	☐	☐	☐	☐
	• Endocrine system disorders, including diabetes, thyroid disease or other endocrine problems	☐	☐	☐	☐
	• Lung disorders, including asthma, emphysema, pulmonary fibrosis, tuberculosis, sleep apnea or other chronic lung or respiratory problems	☐	☐	☐	☐
	• Cystic fibrosis	☐	☐	☐	☐
	• Physical disorder, malformation or infirmity	☐	☐	☐	☐
	• Heart disease or problems with the circulatory system, including hypertension, infarct, angina, stroke, transient ischemic attack (TIA) or other heart, blood vessel or circulatory problems	☐	☐	☐	☐
	• Gastrointestinal disorders, including Crohn's disease and ulcerative colitis, hepatitis, hidden hepatitis, cirrhosis or other liver, pancreas, stomach or intestinal problems	☐	☐	☐	☐
	• Blood disorders, including anemia, leukemia, hemophilia or other blood problems	☐	☐	☐	☐
	• Cerebral, neurological or psychological disorders, including epilepsy, convulsions, dizziness, loss of consciousness, coma, depression, anxiety, eating disorders, job-related burnout, paralysis, multiple sclerosis, motor neuron disorders, Alzheimer's disease, Parkinson's disease or other cerebral, nervous or psychological problems	☐	☐	☐	☐
	• Neurological impairment, including autism spectrum disorder, Rett syndrome, cerebral palsy, muscular dystrophy, hyperactivity, attention deficit disorder, delayed maturation, intellectual disability	☐	☐	☐	☐
	• Problems with kidneys, urinary tract, bladder, prostate, breasts (including abnormal mammogram or ultrasound) or genitals (including abnormal PAP test) or presence of sugar, blood or protein in the urine	☐	☐	☐	☐
	• Muscle, joint and bone conditions, including chronic fatigue, fibromyalgia, arthritis, all forms of lupus, back or neck pain, or other musculoskeletal problems	☐	☐	☐	☐
	• Ear, nose and throat conditions (not including otitis) or eye problems (not including myopia, presbyopia, hyperopia and astigmatism)	☐	☐	☐	☐
	• Other illnesses or medical problems not listed above	☐	☐	☐	☐

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

No.	First name	Nature of illnesses, surgery, accidents, consultations, examinations, treatments, medication, results	Date YYYY MM DD	Length of illness/ disability	Lenght of hospitalization (if applicable)	Name and address of physicians or hospitals
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	
				☐ Days ☐ Months ☐ Years	☐ Days ☐ Months ☐ Years	

E LIFESTYLE QUESTIONNAIRE

⚠ **COMPLETE FOR EACH PROPOSED INSURED.**

			APPLICANT		CHILDREN	
			Yes	No	Yes	No
1	In the **last 10 years**, has the proposed insured had an application for insurance declined or modified, or approved with an exclusion or extra premium? If yes, indicate the reason and the dates:		☐	☐	☐	☐
2	In the **last 5 years**, has the proposed insured had their driver's license suspended or revoked?		☐	☐	☐	☐
3	Has the proposed insured been accused or found guilty of a criminal act within the **last 5 years**?		☐	☐	☐	☐
4	In the **last 12 months**, has the proposed insured used any form of tobacco, including e-cigarettes or other tobacco substitutes?		☐	☐	☐	☐
5	Has the proposed insured received treatment for drug or alcohol addiction, or has a health professional recommended that they reduce their drug or alcohol consumption?		☐	☐	☐	☐
6	How much of the following does the proposed insured consume? *If none, indicate 0.* For alcoholic beverages, 1 serving = 1 bottle of beer (8 ounces) 1 glass of wine (4 ounces) 2 ounces of spirits	Tobacco? *Number of cigarettes per day*				
		E-cigarettes? *Uses per day*				
		Tobacco substitute? *Uses per day*				
		Alcoholic beverages? *Number of servings per week*				
		Drugs or narcotics (including marijuana)? *Number of grams per week and product used*				

F HISTORY

⚠ **COMPLETE FOR EACH PROPOSED INSURED.**

Is there any history in the 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 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 18 and over to be insured (aged 14 and over for Québec)

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 18 and over to be insured (aged 14 and over for Québec)

I 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.

J 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.

PRINT **NEW REQUEST**

GROUP INSURANCE

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

- **You are not required to complete this form for an insurance application.**
- **Note: For the purposes of this form, "CPA IPW" refers to CPA Insurance Plans West.**

APPLICANT INFORMATION

Last name	First name	Date of birth YYYY MM DD

1. I authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, to provide CPA IPW with my personal information after reviewing my insurance application. This information will allow CPA IPW to support me by informing me of the underwriting decisions that are made (e.g., decision to deny coverage, request for additional medical information) and the reasons for these decisions. My personal information will never be sent to my employer.

"Personal Information" may include:

a) Results from medical exams and lab tests

b) Details about my health, including specific illnesses or health problems (e.g., mental illnesses, infectious diseases, use of prescription medication, drugs or alcohol), treatments I've received, or rehabilitation programs I've participated in

c) Information about my health uncovered while reviewing my insurance application, even if this information was unknown to me when I submitted my application

d) Details about my work history or financial situation

e) Traffic offences

f) Criminal Code offences, etc.

2. By signing this authorization form, I acknowledge the following:

a) I have read and understood the nature and scope of this authorization

b) I authorize Desjardins Insurance to disclose my personal information to CPA IPW

c) Desjardins Insurance reserves the right not to disclose personal information to CPA IPW if it could cause serious harm to my health, in which case the information will be sent to a doctor first

d) I can revoke this authorization at any time by contacting CPA IPW

e) This authorization will remain valid for 60 days after Desjardins Insurance makes a decision about my insurance application

A photocopy of this authorization is as valid as the original. Please return the form to CPA IPW along with the insurability form.

Signed in (city, province): _____ **Date (YYYY-MM-DD):** _____

Signature of proposed insured: _____

Signature of legal representative for children under age 16: _____

First and last name of legal representative (please print): _____

PRINT **NEW REQUEST**

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.