CHUBB

GROUP INSURANCE PLAN APPLICATION

For Office Use Only
Firm # ____________ Certificate # ____________

PLEASE PRINT

EMPLOYMENT INFORMATION

Employer ________________________________ Province ____________

Date of full-time employment (DD/MM/YY) ____________ Occupation ____________________

Annual Earnings ____________ # of Hours/Week ________ Class ________ Effective Date ____________

Province of Employment ____________

EMPLOYEE INFORMATION

Last Name [ ] Birthdate [ ] (DD/MM/YY)

First Name [ ] Gender ❑ Male ❑ Female

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Separated
❑ Divorced ❑ Common law (cohabited for at least 12 months)*

Smoking Status ❑ Smoker ❑ Non-Smoker

Language Preference ❑ English ❑ French

*Date cohabitation began (for common-law relationships) [ ] (DD/MM/YY)

Home Address [ ]

City [ ] Province [ ] Postal Code [ ]

SPOUSAL INFORMATION

Last Name [ ] Birthdate [ ] (DD/MM/YY)

First Name [ ] Gender ❑ Male ❑ Female

Smoking Status ❑ Smoker ❑ Non-Smoker

DEPENDENT INFORMATION

	Last Name	First Name	Birthdate (DD/MM/YY)	Gender M/F	Full-time Student (age 21-25)	Disabled Dependent (over age 21)
Child					❑	❑
Child					❑	❑
Child					❑	❑

BENEFICIARY DESIGNATION

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the Policy. Failing such designation, all benefits will be paid to the Estate of the Insured Person.

I hereby name the following revocable beneficiary (Irrevocable in the province of Quebec) for for any Life and/or Accidental Death and Dismemberment 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 designated below. I may elect to change this beneficiary designation at any time.

Beneficiary's Full Name: ____________________ Relationship to You: ____________________

Trustee's Name (if applicable): _________________________________ Relationship to Minor Beneficiary: __________________________

OPTIONAL BENEFIT AMOUNT SELECTION

PLEASE NOTE ➲ *The following section only applies to optional coverages and does not need to be completed for coverage under the standard (i.e. non-optional) group benefits. For further information on available optional benefits, please contact your plan administrator*

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Optional Accidental Death & Dismemberment

❑ Coverage $ ____________ ❑ Employee Only Plan ***or*** ❑ Family Plan

Privacy Statement: When you apply to enroll in the Group Insurance Plan, underwritten by Chubb Life Insurance ("Chubb Life"), the information in Chubb Life's existing insurance files and the information requested on your application is required by Chubb Life, its reinsurers and authorized agents to process your application (*and if approved*), administer your insurance policy, assess claims and investigate misrepresentation. Chubb Life will create a file with your insurance information, and in the event of a claim, with such information as Chubb Life obtains from you and other sources, for the purpose of considering your claim and administering benefits under the Plan. Access to this file will be restricted to those Chubb Life employees, authorized agents and reinsurers who require access to administer the Plan and process claims and persons authorized by law. You may request to review your personal information in this file or request to make a correction by writing to: The Privacy Officer; Chubb Life Insurance, 1400 – 25 York Street, Toronto, ON, M5J 2V5.

I hereby apply for coverage under the Group Life Insurance Plan, underwritten by Chubb Life Insurance, for which I am or may become eligible and authorize any required payroll deductions for administration of my benefits. I certify that the information provided herein is true, accurate and complete; and that I have no other coverage under this plan and have not applied for any.

PLEASE SIGN HERE ➲ Employee's Signature ____________________ Date (DD/MM/YY) ____________