



OPTIONAL CRITICAL ILLNESS APPLICATION

Coverage, if selected, becomes effective on the first of the month following the date Johnstone's Benefits receives your completed application.

YES

Please deduct premiums due for the insurance I have selected below through payroll deductions.

NO

I have been given the opportunity to apply for this insurance, but I do not want to participate.

Employee name: _____ Employee Signature: _____

Date:

IMPORTANT: You must complete this form and return it to your employer, whether or not you choose to participate in the plan.

ENROLLMENT

To participate, check the YES box above, and complete this application. If you do not want this coverage, check the NO box above, and complete the employee's name and signature section of this application. This form is written evidence of your decision to accept or decline coverage. Return it to your plan administrator as soon as possible.

Employee's Name _____

Male Female

Date of Birth

Smoker Non-Smoker

Benefit Selection

No. of Units		Rate per Unit	Monthly Premium
	X		\$ (a)

I HEREBY APPLY for optional critical illness insurance plan, as outlined under the terms of the master policy subscribed by my employer.

I CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits for my dependents, I CONFIRM THAT I AM AUTHORIZED to disclose information concerning them for the purpose of determining their eligibility for coverage.

On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my employer/ policyholder, Johnstone's Benefits and its employees, and the agents, insurers and service providers for the purpose of underwriting, administration, claims processing and the enrollment of myself and my dependents in my employer's/policyholder's optional critical illness insurance plan.

Spouse's Name _____

Only complete spousal information if also applying for coverage.

Male Female

Date of Birth

Smoker Non-Smoker

Benefit Selection

No. of Units		Rate per Unit	Monthly Premium
	X		\$ (b)

Employee name: _____

Employee Signature: _____

Date:

Dependent children coverage can be added to either employee or spousal coverage.

- Add \$5,000 Dependent Children Coverage \$ 1.40/month (c)
- Add \$10,000 Dependent Children Coverage \$ 2.80/month (c)

Benefit Selection TOTAL

Total monthly premiums due	\$	(a+b+c)
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For further details about this and other products contact



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Underwritten by

CHUBB Chubb Life Insurance Company of Canada