the co-operators
A Better Place For You™

# OPTIONAL GROUP LIFE INSURANCE APPLICATION FOR DEPENDENT CHILDREN

Optional life insurance for children provides the parent with an opportunity to purchase life insurance for their dependent children.

## GENERAL INFORMATION

This brochure is designed to outline the benefits for which your child is eligible and does not create or confer any contractual or other rights. All rights with respect to the benefits of an insured person will be governed solely by the Group Policy issued by Co-operators Life Insurance Company.

### Is a Medical Exam Required?

Co-operators Life Insurance Company reserves the right to request a medical examination or other evidence at no expense to you. You will be notified directly if one is required.

### When Does Insurance Take Effect?

Your child's coverage will take effect once you receive written confirmation from MDM Insurance Services Inc.

### How Are Premiums Paid?

Payment of premium is made by payroll deduction.

### How Does It Work?

Coverage is available in units of $10,000 to a maximum of $50,000. You may choose the amount of protection that is right for you.

The cost of this coverage per dependent child is $0.14 per $1,000 of coverage per month. Then:

$10,000 of coverage = $1.40 per month
$20,000 of coverage = $2.80 per month
$30,000 of coverage = $4.20 per month
$40,000 of coverage = $5.60 per month
$50,000 of coverage = $7.00 per month

### How Do I Apply?

To apply, please complete the attached application form and forward to:

MDM Insurance Services Inc.
Group Underwriting
P.O. Box 970
Guelph, Ontario N1H 6N1

For additional information and application forms contact your plan administrator.

Group Policy #: _____

# APPLICATION FOR OPTIONAL GROUP LIFE INSURANCE FOR DEPENDENT CHILDREN

**Entire application must be completed in ink.**
**Copies not acceptable.**

## Applicant Information (please print)

Amount of insurance applied for at this time: $_____ **Coverage is available in units of $10,000 to a maximum of $50,000.**
(Do not include any benefits already in force.)

Status of Applicant: ✘ Child (Please provide name of employee and their employer below)

Name of Employee: _____ Employer: _____

Name of Applicant: _____ Gender: ❒ Male ❒ Female

Address of Applicant: _____
Street City Province Postal Code

Applicant's Date of birth: _____ _____ _____ Telephone #: (Home) _____ (Business) _____
Day Month Year

Is the Applicant currently insured for this coverage? ❒ Yes ❒ No If YES, Group Policy # / PID #: _____

Beneficiary in the event of the Applicant's death:

Full given names: _____ Relationship to Applicant: _____

**Note:** For Child Applications the beneficiary of this insurance will be the employee.

## Applicant's Declaration of Insurability

1. Have you had any symptoms of, or treatment for any medical condition, disorder, or ailment that resulted in your hospitalization within the last 2 years? ❒ Yes ❒ No If YES, give DETAILS in the space provided on the reverse side.

2. What is your present height and weight? Height _____ ❒ ft./in. ❒ cm Weight _____ ❒ lbs. ❒ kg
   Has your weight changed in the past year? ❒ Yes ❒ No
   If YES, how much? _____ Why? _____

3. Are you now, to the best of your knowledge and belief, in good health and free from all symptoms of illness and disease? ❒ Yes ❒ No
   If NO, give DETAILS in the space provided on the reverse side.

4. Are you now under observation or taking treatment or medication from any physician or alternative health care provider for any disorder, ailment, or condition? (Alternative health care provider includes herbalist, acupuncturist, chiropractor, or practitioner of homeopathy or naturopathy, etc.)
   ❒ Yes ❒ No If YES, what? _____
   Why? _____

5. Who is your regular physician or family doctor? _____
   Address: _____
   Street City Province Postal Code
   Date last seen: _____ _____ _____ Reason and result: _____
   Day Month Year

6. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? ❒ Yes ❒ No If yes, give details:
   _____

| 7. | Have you ever had or been told you had any of the following: | **Yes** | **No** |
|---|---|---|---|
| a) | Lung or respiratory disorder (e.g., asthma, bronchitis, tuberculosis, emphysema)? | ❒ | ❒ |
| b) | Heart trouble (e.g., chest pain, shortness of breath, high blood pressure, rheumatic fever, murmur, heart attack, or stroke)? | ❒ | ❒ |
| c) | Stomach trouble (e.g., ulcer, appendicitis, gall bladder, hernia, colitis, or other digestive disorder)? | ❒ | ❒ |
| d) | Diabetes, kidney disease, sexually transmitted disease, or abnormal urine? | ❒ | ❒ |
| e) | Cancer, cyst, tumour, growth, or blood disorder? | ❒ | ❒ |
| f) | Epilepsy, paralysis, dizziness, or nervous or mental disorder? | ❒ | ❒ |
| g) | Neuritis, arthritis, rheumatism, or back, spine, bone joint, or muscle disorder? | ❒ | ❒ |
| h) | Nervous disorders, including depression, severe anxiety, or suicidal thoughts? | ❒ | ❒ |
| i) | AIDS or an AIDS related complex, or a positive reaction to a test designed to reveal the presence of Human Immunodeficiency Virus (HIV), or any other immunological disorder? | ❒ | ❒ |

*Question #7 continued on reverse side of this form.*

| 7 | | Yes | No |
|---|---|---|---|
| j) | Hepatitis A, B, C, or type unknown, or any other disorder of the liver? | ❒ | ❒ |
| k) | Any disease, impairment, or deformity not named above? | ❒ | ❒ |

**If YES to question #1, if NO to question #3, or if YES to any of the questions in #7, provide details below. Attach additional sheet(s) if required.**

| Name of disorder, ailment, etc. | Date of | | Result | Attending Physician or Hospital |
|---|---|---|---|---|
| | Onset | Recovery | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

8. Have you ever taken drugs, including marijuana and cocaine, for other than medical purposes or been advised to reduce alcohol consumption or received or have been counselled to receive treatment for drug addiction or alcoholism? ❒ Yes ❒ No If YES, give details:

_____

9. Have you ever been refused life insurance or offered insurance modified in any way? ❒ Yes ❒ No

If YES, give details, including date(s) and reason(s): _____

_____

10. Have you smoked any Tobacco Products within the past 12 months? (Tobacco products include cigarettes, cigarillos, cigars, mini cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana, or hashish.) ❒ Yes ❒ No

## Privacy Statement

MDM Insurance Services Inc. ("MDM") and Co-operators Life Insurance Company ("Co-operators") are committed to protecting the privacy, confidentiality, accuracy, and security of the personal information that they collect, use, retain, and disclose in the course of conducting business.

## Applicant's Declaration and Authorization

The Applicant includes the Parent or Guardian of a child under 16 years of age to be insured.

I hereby authorize any physician, hospital, clinic, or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me or my child under age 16 years to release to and exchange with MDM, Co-operators, the group plan administrator or their representatives and/or agents, any and all such information necessary for any or all of the following purposes: to underwrite my Application for insurance coverage, evaluate my eligibility for coverage, and adjudicate all claims.

I further authorize MDM, Co-operators, the group plan administrator or their representatives and/or agents to request I or my child under age 16 years, undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for such purposes.

I understand that my refusal or withdrawal of consent may result in the delay or denial of my Application.

I acknowledge that any information obtained from any paramedical or medical examination, any medical evidence form(s), questionnaire(s), or any other written statements completed and furnished as evidence of insurability shall form part of this Application and I declare that all such information and the information provided in this Application to be true, complete, and accurate. I acknowledge that any failure to disclose or any misrepresentation of any material fact may void the policy.

This authorization shall remain valid until revoked in writing by me. Any copy of this authorization shall be as valid as the original. I authorize my employer to deduct regularly from my salary any contribution required by me.

Applicant's Signature
(if age 16 or over): _____ Date Signed: _____

Employee's Signature: _____ Date Signed: _____

Parent or Guardian Signature (application for child under age 16 years):

_____ Date Signed: _____

**This form must be received in our office within 60 days of the above date, otherwise a new application must be completed.**
**Return the completed Application form via mail to: MDM Insurance Services Inc., Group Underwriting, P.O. Box 970, Guelph ON N1H 6N1.**