# Application For Insurance
## CVMA Affinity Program

CVMA INSURANCE PROGRAM

## Member Information

| Name (first, initial, last) | Birth Date (yy/mm/dd) | Gender ❑ M ❑ F |
|---|---|---|
| Address | City / Province | Postal Code |
| Telephone Number | Gross Earnings $ Monthly | |
| *Hours Worked Per Week | Months Worked Per Year | |
| Occupation/Clinic Name | CVMA Membership Number | |

*** Eligibility – Full time employees working a minimum of 20 hours per week.**

## Member Coverage Information

Are you applying for an increase in your current coverage? ❑ Yes ❑ No

| | | | |
|---|---|---|---|
| **Life Insurance** (Available in units of $20,000 to a maximum of $800,000) | Member ❑ | Amount $ | Smoker Status ❑ Yes ❑ No |
| **Accidental Death & Dismemberment** (Available in units of $20,000 to a maximum of $300,000) | Member ❑ | Amount $ | |
| **Child Dependent Life** ($10,000) | ❑ Yes ❑ No | | |
| **Business Overhead Expense** (Available in units of $100. Minimum of $2,000, Maximum $10,000) | ❑ | Amount $ | |
| **Long Term Disability** (66.7% of monthly earnings on the first $2,750, 40% of exceeding salary, maximum $8,000, month) | ❑ | Amount $ | Waiting Period ❑ 30 Days ❑ 90 Days / Definition of Disability ❑ Own Occupation ❑ Any Occupation |

***When applying for LTD, please provide complete copies of your last year's personal and corporate (if applicable) tax returns and financial statements.**

**Beneficiary Designation**
If no beneficiary is assigned then "ESTATE" will be assumed. If benefits are assigned to minor children a trustee must be appointed to act on their behalf.

| Beneficiary Name (first, initial, last) | Birth Date (yy/mm/dd) | % Allocated | Relationship to Employee |
|---|---|---|---|
| Beneficiary Name (first, initial, last) | Birth Date (yy/mm/dd) | % Allocated | Relationship to Employee |
| Name of Trustee(s) for Dependent Children | | | Relationship to Employee |

**The Insurer merely records designations or changes beneficiaries and declines any responsibility as to their validity. This designation applies to all life benefits under the policy.**

## Spousal Coverage Information - If applying for Spousal Life Insurance, please complete this section.

| Name (first, initial, last) | Birth Date (yy/mm/dd) | Gender ❑ M ❑ F |
|---|---|---|

| | | | |
|---|---|---|---|
| **Life Insurance** (Available in units of $20,000 to a maximum of $800,000) | ❑ | Amount $ | Smoker Status ❑ Yes ❑ No |

**Beneficiary Designation**
If no beneficiary is assigned then "ESTATE" will be assumed. If benefits are assigned to minor children a trustee must be appointed to act on their behalf.

| Beneficiary Name (first, initial, last) | Birth Date (yy/mm/dd) | % Allocated | Relationship to Employee |
|---|---|---|---|
| Beneficiary Name (first, initial, last) | Birth Date (yy/mm/dd) | % Allocated | Relationship to Employee |
| Name of Trustee(s) for Dependent Children | | | Relationship to Employee |

**The Insurer merely records designations or changes beneficiaries and declines any responsibility as to their validity. This designation applies to all life benefits under the policy.**

***Please complete reverse side.***

## Invoice Option

**Preferred method to receive your monthly billing statement:**

❑ Email

Provide Email Address : _____

❑ Regular Mail

## Bank or Financial Institution Information

**Monthly** – Automatic withdrawals will occur on the first day of each month.

**The bank specified below is authorized and requested to debit my account in accordance with this agreement for all premiums payable to Western Financial Group Insurance Solutions for my/our Insurance costs.**

| Name of Bank or Financial Institution | | | |
|---|---|---|---|
| Branch Address | City | Province | Postal Code |

- Your treatment of each cheque or debit shall be the same as if I/we had personally issued a cheque.
- Delivery of this authorization to you constitutes delivery by me/us.
- This authorization can be cancelled by me/us at any time upon written notice.
- I/We will ensure that funds are available to cover the amount of withdrawal, as notified to me/us by Western Financial Group Insurance Solutions.
- $10.00 service fee will be charged to each (P.A.C) returned for non-sufficient funds (NSF).

**Please attach a void cheque:**

VOID CHEQUE

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group Insurance Solutions, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

• our employees and representatives in the performance of their jobs;
• persons to whom you have granted access in writing; and
• persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group Insurance Solutions is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about Western Financial Group Insurance Solutions' commitment to privacy and security refer to our website: www.westernfgis.ca

* I hereby certify that I am an active member of the CVMA.

| Member Signature | Date (yy/mm/dd) |
|---|---|

**In order to process your application for insurance, medical underwriting is required. Please attach a completed Evidence of Insurability Form for each person applying for insurance.**