CVMA INSURANCE PROGRAM

Student & Graduate Insurance Program
Application Form

SECTION 1 – Member Information (please print)

First Name and Middle Initial		Surname (include maiden name [in brackets], if applicable)
❑ Male ❑ Female	❑ Ms ❑ Miss ❑ Mr ❑ Mrs ❑ Dr	Date of Birth (dd/mm/yy)

College Attending		Student ID Number
Mailing Address		City/Town
Province/Territory	Postal Code	Telephone Number
Cellular Telephone Number	E-mail Address	

Smoking Status ❑ Smoker ❑ Non-Smoker	**Note:** To be considered a non-smoker, you must not have used any products containing nicotine in the past twelve consecutive months (including but not limited to, cigarettes, cigars, pipes, smokeless tobacco, nicotine gum, nicotine patch or other smoking cessation products).

SECTION 2 – Coverage

Benefit	Coverage Amount
Life Insurance	$25,000
Accidental Death and Dismemberment	$25,000
Long Term Disability	$2,000 monthly benefit

Indicate the name(s) of your designated beneficiary(ies) in full below. **Note:** Spousal designation in Quebec is irrevocable unless you specifically write "revocable" below.
If spouse is beneficiary, designation is ❑ Revocable ❑ Irrevocable

Beneficiary Name	% Allocated	Relationship to Plan Member
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If the beneficiary is under age 18, please provide the name of a Trustee and relationship to the Beneficiary.

Important Conditions
- The amount of disability benefits will be reduced by any benefits or payments received from any other source.
- Graduates can remain on the Student & Graduate Insurance Program until they become CVMA members.
- Benefits will not be paid for any condition which you received medical treatment, consultation, care or medication 24 months prior to the effective date of the Insurance. This limitation only applies during the first 2 years of coverage.

SECTION 3 – Pre-Authorized Chequing

- 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 charged to each P.A.C. returned for non-sufficient funds (NSF).

Please attach a void cheque to this application form as it is a mandatory requirement.

Monthly Payment:
Automatic withdrawals will occur on the first of every month.

Signature of Member	Date (dd/mm/yy)

SECTION 4 – Agreements and Authorization

Declarations

I declare that the statements made on this Application are true and complete and form part of any certificate issued.

I agree that acceptance of any certificate issued constitutes approval of the provisions of the certificate and ratifications of any additions, endorsements or amendments.

I agree that any certificate issued takes effect on the 1st of the month following approval, delivery and full payment of the first premium and then only if there has been no change in my insurability, subsequent to the completion of this Application.

I authorize Western Financial Group Insurance Solutions and it's participating Reinsurers, to collect, use and disclose personal information concerning me for the purpose of determining my eligibility for insurance; underwriting and administering coverage and adjudicating and paying claims. I acknowledge that further information concerning the collection, use and disclosure of personal information by Western Financial Group Insurance Solutions may be found in Western Financial Group Insurance Solutions' Privacy Policy and Privacy Information Package, available at www.westernfgis.ca or by request.

I authorize Western Financial Group Insurance Solutions to exchange the personal information obtained during review of this Application, or any claim made under the certificate issued with Western Financial Group Insurance Solutions and its Reinsurers.

I authorize Western Financial Group Insurance Solutions to include this personal information in any other files which Western Financial Group Insurance Solutions currently holds in respect of me, or which may be opened in the future. I authorize Western Financial Group Insurance Solutions to refer to any existing files, opened or closed that they currently hold regarding me.

I understand that if death occurs within two years from the effective date as shown on the Certificate, the amount payable is limited to a return of premiums I have paid.

Signature	Date (dd/mm/yy)

Western FINANCIAL GROUP

Complete and send to: Employee Benefits Service Centre
Western Financial Group Insurance Solutions
201-600 Empress Street, Winnipeg, MB R3G 0R5
Toll Free: 1-866-860-CVMA (2862)

Western Financial Group (Network) Inc.
April 2010