Side A

Keeping pace with you!

As a regular member in good standing of the Canadian Union of Postal Workers (CUPW), you are entitled to receive **$8,000** of life insurance AND **$8,000** of accidental death and dismemberment insurance FREE OF CHARGE*.

Plus, **your spouse** is entitled to receive **$4,000** of life insurance coverage FREE OF CHARGE*, through the union. *As well,* **each of your eligible children** are entitled to receive **$2,000** of coverage, absolutely free via the sponsorship of the CUPW.

*Coverage provided compliments of the CUPW Insurance Trust.

COUGHLIN & ASSOCIATES LTD.

Box 3519, Station C
Ottawa, Ontario
K1Y 4G1

To receive this complimentary coverage *fill out Steps 1, 2 and 5 (on reverse)*

Or to take advantage of the optional group life insurance

fill out Steps 1, 2, 3, 4 and 5

MEMBER INFORMATION

Sun Life Financial

This coverage is underwritten by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Policy #: 87032

STEP 1 mandatory information

LAST NAME	FIRST NAME	INITIAL

DATE OF BIRTH (y/m/d)	CUPW IDENTIFICATION NUMBER (Mandatory)	GENDER	LANGUAGE
		❑ Male ❑ Female	❑ English ❑ French

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

TELEPHONE (Home)	EMAIL ADDRESS (Home)
( )	

TELEPHONE (Work)	EMAIL ADDRESS (Work)
( )	

BENEFICIARY DESIGNATION

BENEFICIARY LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (y/m/d)	RELATIONSHIP TO PLAN MEMBER
BENEFICIARY LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (y/m/d)	RELATIONSHIP TO PLAN MEMBER
BENEFICIARY LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (y/m/d)	RELATIONSHIP TO PLAN MEMBER

(The beneficiary for the spousal or children's coverage will be the member, if living, otherwise the member's estate.)

You must make your beneficiary designation revocable or irrevocable by checking one of the boxes below. You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be *irrevocable* unless you check the box marked "Revocable".

I hereby make the above beneficiary(ies) designation: ❑ Revocable ❑ Irrevocable

Member signature ____________________ **Date**(y/m/d) ____________________

SPOUSAL INFORMATION (IF APPLICABLE)

STEP 2 mandatory information for family coverage

LAST NAME	FIRST NAME	INITIAL

DATE OF BIRTH (y/m/d)	GENDER
	❑ Male ❑ Female

CHILDREN'S COVERAGE

❑ Check here if you wish to insure each of your eligible children for $10,000 under this plan for only $2 more per month. The member in good standing coverage or spousal coverage must also be taken in conjunction with this coverage.

CHILD'S NAME	DATE OF BIRTH (y/m/d)

PLUS!

Receive up to **$250,000** of additional life insurance coverage **at a surprisingly low cost!**
Simply complete the information on the reverse.

Apply for this CUPW-sponsored insurance coverage TODAY!

COUGHLIN & ASSOCIATES LTD.

For more information on this special offer please visit:

www.coughlin.ca/cupw

Application for *optional group life insurance coverage*

COVERAGE SELECTION

STEP 3 total optional coverage requested

In addition to the free basic insurance, please enrol me in the optional group term life and AD&D plan for the amount indicated in the box below:

APPLICANT
❑ $25,000 ❑ $50,000 ❑ $75,000 ❑ $100,000 ❑ $125,000 ❑ $150,000 ❑ $175,000 ❑ $200,000 ❑ $250,000

SPOUSE
❑ $25,000 ❑ $50,000 ❑ $75,000 ❑ $100,000 ❑ $125,000 ❑ $150,000 ❑ $175,000 ❑ $200,000 ❑ $250,000

MEDICAL QUESTIONNAIRE

STEP 4 mandatory for optional life coverage

Member Height ❑ ft./in. ❑ cm **Spouse Height** ❑ ft./in. ❑ cm

Member Weight ❑ lbs. ❑ kg **Spouse Weight** ❑ lbs. ❑ kg

1. Have you used tobacco products in the past 12 months? **Member** ❑ Yes ❑ No **Spouse** ❑ Yes ❑ No
2. Within the past three years have you had an application for life or disability insurance declined or assessed at a rate higher than a standard premium rate? **Member** ❑ Yes ❑ No **Spouse** ❑ Yes ❑ No
3. Within the past three years, have you i) received any treatment for? (including taking pills, injections or other medications); or ii) consulted a physician; or iii) been diagnosed as having:

	Member	Spouse
Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)	❑ Yes ❑ No	❑ Yes ❑ No
Any test indicating the presence of the HIV (AIDS) virus?	❑ Yes ❑ No	❑ Yes ❑ No
Cancer?	❑ Yes ❑ No	❑ Yes ❑ No
Diabetes?	❑ Yes ❑ No	❑ Yes ❑ No
High blood pressure?	❑ Yes ❑ No	❑ Yes ❑ No
Heart problems?	❑ Yes ❑ No	❑ Yes ❑ No
Stroke?	❑ Yes ❑ No	❑ Yes ❑ No
Liver disorder?	❑ Yes ❑ No	❑ Yes ❑ No
Kidney disorder?	❑ Yes ❑ No	❑ Yes ❑ No
Psychiatric or psychological problems?	❑ Yes ❑ No	❑ Yes ❑ No
Lung and/ or respiratory disorder?	❑ Yes ❑ No	❑ Yes ❑ No
Neurological disorder?	❑ Yes ❑ No	❑ Yes ❑ No
Digestive disorder?	❑ Yes ❑ No	❑ Yes ❑ No
Chronic Fatigue Syndrome?	❑ Yes ❑ No	❑ Yes ❑ No
Alcohol or drug abuse?	❑ Yes ❑ No	❑ Yes ❑ No
Arthritis or back problems?	❑ Yes ❑ No	❑ Yes ❑ No

4. Within the past three years, have you been admitted or advised to be admitted as a patient in a hospital or clinic (except for pregnancy or birth) for longer than five consecutive days? **Member** ❑ Yes ❑ No **Spouse** ❑ Yes ❑ No

If "yes" to any answer, please provide details:

Member

Spouse

AUTHORIZATION & DECLARATION

STEP 5 mandatory completion

I authorize Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; **I authorize** Coughlin to exchange my personal information with the following persons, organizations or parties; insurance companies and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, **I confirm** that I am authorized to act on their behalf. **I agree** that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original. **I certify** that the information given is true, correct and complete to the best of my knowledge.

You must be authorized to disclose information about your spouse and dependents in order to enroll them in the plan. By enrolling in this plan, you authorize the following: Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims, Your plan sponsor and its administrator, Coughlin & Associates Ltd. to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required. All information in this form is true and complete. A photocopy or electronic version of this authorization is as valid as the original.

Member signature (for optional life insurance coverage) **Date**(y/m/d)

Spouse signature (for spouse's optional life insurance coverage) **Date**(y/m/d)

Protecting your personal information The administrator of your group benefits plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

Insurance coverage to keep pace with your changing lifestyle -- *even after age 65*

CONFIRMATION OF APPLICATION

Please detach and keep for your records

I applied for: **$** ____________________
of coverage from the CUPW group life insurance plan.

My estimated monthly premium will be: **$** ____________

My spouse applied for: **$** ____________________
of coverage from the CUPW optional group life insurance plan.

The estimated monthly premium will be: **$** ____________

The maximum coverage available is $250,000. Premiums are based on your age, gender and smoking habits. Premiums are re-calculated each January 1, based on your age and smoker status.

Rates per $25,000 of coverage

Age	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker
Under age 40	$2.30	$4.40	$1.95	$3.65
40 to 44	$3.35	$7.25	$3.35	$5.10
45 to 49	$6.55	$13.20	$5.85	$9.35
50 to 54	$11.50	$23.05	$9.35	$15.35
55 to 59	$21.00	$38.75	$14.95	$23.10
60 to 64	$30.50	$53.15	$19.85	$29.70
65 to 69	**$44.68**	**$87.23**	**$28.40**	**$46.20**

Example: A 38-year-old male, non-smoker, could receive $100,000 of insurance protection (4 X $25,000) for $9.20 (4 X $2.30) per month.