



# Keystone Agricultural Producers Member Benefits Program

## APPLICATION FOR GROUP INSURANCE BENEFITS

Co-operators Life Insurance Company, Group Policy Number G.8582

This application is a legal document. It must be completed in INK and all changes **MUST BE INITIALED**.

### SECTION 1 – PERSONAL INFORMATION

Applicant Family Name	Full First Name	Middle Initial(s)	Date of Birth Month   Day   Year	Sex M or F <input type="checkbox"/> <input type="checkbox"/>
Spouse Family Name	Full First Name	Middle Initial(s)	Date of Birth Month   Day   Year	Sex M or F <input type="checkbox"/> <input type="checkbox"/>
Child Family Name	Full First Name	Middle Initial(s)	Date of Birth Month   Day   Year	Sex M or F <input type="checkbox"/> <input type="checkbox"/>
Child Family Name	Full First Name	Middle Initial(s)	Date of Birth Month   Day   Year	Sex M or F <input type="checkbox"/> <input type="checkbox"/>
Child Family Name	Full First Name	Middle Initial(s)	Date of Birth Month   Day   Year	Sex M or F <input type="checkbox"/> <input type="checkbox"/>
Child Family Name <sup>1</sup>	Full First Name	Middle Initial(s)	Date of Birth Month   Day   Year	Sex M or F <input type="checkbox"/> <input type="checkbox"/>

Address: \_\_\_\_\_  
 Box No./Street Name & No.                      Town                      Province                      Postal Code

Numbers: Home (    ) \_\_\_\_\_-\_\_\_\_\_      Fax (    ) \_\_\_\_\_-\_\_\_\_\_      E-mail Address: \_\_\_\_\_

Applicant is:                       Member of Keystone Agricultural Producers                       Employee\*\* of Member

Membership No. \_\_\_\_\_

*\*\* If Applicant is an Employee of Member, please complete:*      Employer's Name: \_\_\_\_\_

Employer's Membership No. \_\_\_\_\_

The Effective Date of all selected coverage will be the first of the month following the later of:

1. date of approval (unless otherwise noted), and
2. confirmation of Keystone Agricultural Producers membership.

**Co-operators Life Insurance Company Privacy Statement**

Co-operators Life Insurance Company ("Co-operators") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

FOR ADMINISTRATIVE PURPOSES ONLY:                      Date Application Received: \_\_\_\_\_

Existing Coverage Personal Certificate No. \_\_\_\_\_

**SECTION 2 – TYPES OF COVERAGE APPLIED FOR**

Premium Amount

2.1  **CORE PLUS PLAN** *(Ambulance, Hospital, Out-of-Province/Country Emergency Travel Health, Prescription Drugs, Paramedicals, Eye Exams, Hearing Aids)*

Applicant Only       Applicant and Spouse       Applicant, Spouse and Children      \$ \_\_\_\_\_

2.2  **CORE PLUS DENTAL PLAN** *(Ambulance, Hospital, Out-of-Province/Country Emergency Travel Health, Prescription Drugs, Paramedicals, Eye Exams, Hearing Aids, Dental Rider 80% Basic, 50% Major Services)*

Applicant Only       Applicant and Spouse       Applicant, Spouse and Children      \$ \_\_\_\_\_

2.3  **OPTIONAL LIFE INSURANCE**

**Applicant**       New Enrollment for Total Coverage of \$ \_\_\_\_\_      \$ \_\_\_\_\_  
 or  Increase in Coverage to Total of \$ \_\_\_\_\_

**Spouse**       New Enrollment for Total Coverage of \$ \_\_\_\_\_      \$ \_\_\_\_\_  
 or  Increase in Coverage to Total of \$ \_\_\_\_\_

**Coverage:** Available in units of \$25,000 each    Maximum: \$500,000

Note for Applicant: Remember to complete the Beneficiary Designation below. If you do not complete the Beneficiary Designation, benefits will be paid to your estate.

Note for Spouse: For any claim relating to Spousal coverage, the applicant shall be the beneficiary unless otherwise indicated below.

2.4  **DEPENDENT LIFE INSURANCE (Prerequisite: Applicant Optional Life coverage\*)**

**Coverage:** \$10,000 per dependent child from 15 days old to 21 years of age or \$1,000 if under 15 days old      \$ \_\_\_\_\_

\* **Applicant** Optional Life coverage must also be applied for at this time or already be in effect under this policy.

The beneficiary of this insurance is the owner of the policy.

**2.5 Beneficiary Designation for Optional Life Insurance Coverage:**

I hereby appoint the following to receive all benefits payable in the event of my death, including, unless otherwise indicated, all optional coverage even where the optional coverage is purchased at different times. This beneficiary designation shall extend to any group insurance contracts that replace the group insurance contract in force at the date of the completion of this designation.

**Applicant**

**Spouse**

**Primary Beneficiary(ies)** – in equal shares unless other percentage indicated

Name of Beneficiary	Relationship	% Share

Name of Beneficiary	Relationship	% Share

In the event the Primary Beneficiary(ies) predeceases the Insured, the following Contingent Beneficiary(ies) shall be entitled to benefits:

**Contingent Beneficiary(ies)** – in equal shares unless other percentage indicated

Name of Beneficiary	Relationship	% Share

Name of Beneficiary	Relationship	% Share

In the event all Beneficiaries predecease the Insured, benefits shall be paid to the Insured's estate.

Policy proceeds cannot be paid to a minor. If a minor is named as a beneficiary, you should name a trustee. If naming a trustee, you may want to consider creating a trust agreement or referencing an existing trust agreement.

Trustee: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

**SECTION 3 – MEDICAL INFORMATION**

Complete all questions below on behalf of all proposed insureds. Provide full details below or attach a separate sheet (signed & dated).

Applicant	Spouse	Dependent child
3.1a) Name and address of personal Physician or Doctor last Consulted _____	3.1b) Name and address of personal Physician or Doctor last Consulted _____	Name: _____ 3.1c) Name and address of personal Physician or Doctor last Consulted _____
3.2a) Date of last consultation _____	3.2b) Date of last consultation _____	3.2c) Date of last consultation _____
3.3a) Reason for last consultation _____	3.3b) Reason for last consultation _____	3.3c) Reason for last consultation _____
3.4a) Treatment, Medication prescribed _____	3.4b) Treatment, Medication prescribed _____	3.4c) Treatment, Medication prescribed _____
3.5a) Results and current status _____	3.5b) Results and current status _____	3.5c) Results and current status _____

Applicant	Spouse
3.6a) Height _____ <input type="checkbox"/> ft/in <input type="checkbox"/> cm Weight _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg	3.6b) Height _____ <input type="checkbox"/> ft/in <input type="checkbox"/> cm Weight _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg
3.7a) In the past year, weight has <input type="checkbox"/> Remained same <input type="checkbox"/> Increased <input type="checkbox"/> Decreased Reason for change: _____	3.7b) In the past year, weight has <input type="checkbox"/> Remained same <input type="checkbox"/> Increased <input type="checkbox"/> Decreased Reason for change: _____

<i>Complete all questions below on behalf of all proposed insureds. Provide full details, at the end of Section 3 or attach a separate sheet (signed &amp; dated).</i>		<i>Applicant</i>		<i>Spouse</i>		<i>Dependent Children</i>	
		Yes	No	Yes	No	Yes	No
3.8	Have you ever had, been told you have, or received treatment, medication, advice or counselling for any of the following: heart trouble, high blood pressure, ulcerative colitis, kidney disorder, diabetes, stroke, or any mental or nervous disorder including stress, depression or anxiety, alcoholism, lung disorder, cancer or tumour, hepatitis, liver disorder or blood disorder, disorder of joints or limbs, including neck and back pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.9	Have you ever had, been told you have, or received treatment, medication, advice or counselling for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or had a positive test related to HIV, HTLV virus or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.10	At any time, in the last five (5) years, have you consulted a physician, or any Alternative Health Care Provider for any disease ailment, injury or mental condition not already disclosed above? (Alternative Health Care Provider includes: herbalist, acupuncturist, chiropractor, or practitioner of homeopathy, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.11	Are you now under observation or taking treatment or medication from any physician or Alternative Health Care Provider for any disorder, ailment or condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.12	Do you have any condition for which hospitalization or surgery has been advised or is contemplated within the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.13	Have you used any Tobacco Products within the last 12 months? (tobacco products include: cigarettes, cigarillos, mini-cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana or hashish)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.14	Have you ever been declined Life or Disability insurance or been offered insurance which has been modified or rated in any way?.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For every "YES" answer given in questions 3.8 through 3.14, please provide full details. If more space is required, attach a separate sheet (signed and dated).

Proposed Insured	Question number	Reason for consultation	Date of first visit/treatment	Date of last visit/treatment	Current status	Name/address of Physicians/Hospitals

3.15 If any proposed insured is using medication or serum, or expects to in the future, please complete the following:

Proposed Insured	Name of medication and reason prescribed	Monthly cost	Strength	Daily dosage	Length of time taking

**SECTION 4 – DECLARATION AND AUTHORIZATION**

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 to release to and exchange with 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 Co-operators, the group plan administrator or their representatives and/or agents to request I 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.

Signature of Applicant \_\_\_\_\_ Date: \_\_\_\_\_ (dd/mm/yy)

Signature of Spouse (if applying) \_\_\_\_\_ Date: \_\_\_\_\_ (dd/mm/yy)

Signature of Dependent Child (if over 16 and if applying) \_\_\_\_\_ Date: \_\_\_\_\_ (dd/mm/yy)

Signature of Dependent Child (if over 16 and if applying) \_\_\_\_\_ Date: \_\_\_\_\_ (dd/mm/yy)

**PLEASE ENSURE THAT ALL QUESTIONS ARE ANSWERED COMPLETELY AND ALL CHANGES ARE INITIALED IN ORDER TO AVOID UNNECESSARY DELAYS IN PROCESSING YOUR APPLICATION.**

**FOR INFORMATION REGARDING COMPLETION OF THIS APPLICATION,  
CALL THE KAP MEMBER BENEFITS TOLL-FREE HELP LINE AT:**

**1-866-527-0123, ext 1**

or

**e-mail kapbenefits@stratabenefits.ca**

When possible, please fax application form to 1-866-984-9460 for review prior to mailing original. We will review the application and advise of any areas that require further completion. Completed applications should be forwarded my mail to the Plan Administrator:

**STRATA Benefits Consulting Inc. ~~ 2nd Floor – 1447 Waverley St. ~~ Winnipeg MB R3T 0P7**