



Application For Insurance

CVMA Affinity Program

Member Information

Name (first, initial, last)	Birth Date (yy/mm/dd)	Gender <input type="checkbox"/> M <input type="checkbox"/> 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 <small>(Available in units of \$20,000 to a maximum of \$800,000)</small>	Member <input type="checkbox"/>	Amount \$ _____	Smoker Status <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Dependent Life (\$10,000)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Business Overhead Expense <small>(Available in units of \$100. Minimum of \$2,000, Maximum \$10,000)</small>	<input type="checkbox"/>	Amount \$ _____		
Long Term Disability <small>(66.7% of monthly earnings on the first \$2,750, 40% of exceeding salary, maximum \$8,000, month)</small>	<input type="checkbox"/>	Amount \$ _____	Waiting Period <input type="checkbox"/> 30 Days <input type="checkbox"/> 90 Days	Definition of Disability <input type="checkbox"/> Own Occupation <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	
Life Insurance <small>(Available in units of \$20,000 to a maximum of \$1,500,000)</small>	<input type="checkbox"/>	Amount \$ _____	Smoker Status <input type="checkbox"/> Yes <input type="checkbox"/> 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:

E-mail

Provide E-mail 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.

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

Member Signature

Date

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.

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 web site: www.westernfgis.ca



Complete and send to:

CVMA Insurance Program, Western Financial Group Insurance Solutions

777 Portage Avenue, Winnipeg, MB R3G 0N3

Toll Free: 1-866-860-CVMA (2862)

Western Financial Group (Network) Inc.

3100-CE/05-2010