Enrollment Form
Guaranteed Critical Illness Coverage

EMPLOYER SECTION

POLICY NUMBER	DIVISION / UNIT
EMPLOYER	

APPLICANT SECTION

EMPLOYEE'S NAME	PROVINCE OF RESIDENCE

EMPLOYEE

NAME OF APPLICANT	DATE OF BIRTH DD / MM / YYYY		
GENDER ☐ M ☐ F	☐ Smoker ☐ Non-smoker	AMOUNT OF PRINCIPAL SUM $20,000.00	CURRENT MONTHLY PREMIUM (INCREASES WITH AGE)
HAVE YOU SMOKED ANY CIGARETTES, CIGARELLOS, CIGARS, MARIJUANA, USED PIPES OR CHEWING TOBACCO OR ANY NICOTINE PRODUCTS (PATCH, GUM) WITHIN THE PAST 12 MONTHS? ☐ YES ☐ NO			IF YES, PLEASE PROVIDE DETAILS
SIGNATURE			DATE DD / MM / YYYY

☐ New insurance ☐ Change in amount ☐ Change in name

SPOUSE

NAME OF APPLICANT	DATE OF BIRTH DD / MM / YYYY		
SEX ☐ M ☐ F	☐ Smoker ☐ Non-smoker	AMOUNT OF PRINCIPAL SUM $20,000.00	CURRENT MONTHLY PREMIUM (INCREASES WITH AGE)
HAVE YOU SMOKED ANY CIGARETTES, CIGARELLOS, CIGARS, MARIJUANA, USED PIPES OR CHEWING TOBACCO OR ANY NICOTINE PRODUCTS (PATCH, GUM) WITHIN THE PAST 12 MONTHS? ☐ YES ☐ NO			IF YES, PLEASE PROVIDE DETAILS
SIGNATURE			DATE DD / MM / YYYY

☐ New insurance ☐ Change in amount ☐ Change in name

DEPENDENT CHILD

NUMBER OF CHILDREN	AMOUNT OF PRINCIPAL SUM $10,000.00		
NAMES	SEX ☐ M ☐ F	☐ Smoker ☐ Non-smoker	DATE OF BIRTH DD / MM / YYYY
NAMES	SEX ☐ M ☐ F	☐ Smoker ☐ Non-smoker	DATE OF BIRTH DD / MM / YYYY
NAMES	SEX ☐ M ☐ F	☐ Smoker ☐ Non-smoker	DATE OF BIRTH DD / MM / YYYY
EMPLOYEE'S SIGNATURE			DATE DD / MM / YYYY

☐ New insurance ☐ Change in amount ☐ Change in name

AUTHORIZATION

☐ I authorize the deduction from my salary of the premiums for the insurance applied for as shown above.

☐ I have been given the opportunity to apply for this insurance but I do not desire to participate.

EMPLOYEE'S SIGNATURE	DATE DD / MM / YYYY

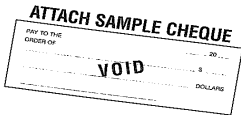
CustomCare Inc.
#210, 200 Quarry Park Blvd. SE
Calgary, Alberta T2C 3E5
(403)640-6620

Critical Illness Coverage

Pre-Authorized Cheque (PAC) Agreement

BANKING DATA

Branch No. (5 figures):________________________ Institution (3 figures): ____________



Account No. (12 figures):___________________________

Name as shown on bank records: __________________________________

CustomCare Inc. is authorized to draw a cheque for monthly recurring payments in accordance with its Pre-authorized cheque plan and to exchange personal information with the financial institution in order to execute this agreement. NOTE: Transaction fees may be charged for any cheque that is not honoured by your financial institution. I confirm that the banking information accurately corresponds to my account.

___________________________________ Signature (as shown on bank records)

________________________________ (Other signature (joint account)

You have certain recourse right if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca .

Coverage Provided By

Contact: CustomCare Inc. #210, 200 Quarry Park Blvd. SE – Calgary, AB. T2C 5E3 (403) 640-6620 Toll Free 1-866-820-2188