intact public entities

Critical Illness Application

NOTES: **Coverage is applicable to Board Members only**
This application must be completed for each individual applying for Critical Illness Coverage
If the Applicant answers "Yes" to having any of the conditions or procedures below, they are not eligible for coverage

Named Insured ______________________ Policy Number ______________

Name of Individual Applicant ______________________

Mailing Address of Individual Applicant ______________________

Occupation and Title of Individual Applicant ______________________

Date of Birth (dd/mm/yy) of Individual Applicant ______________________

During the past two (2) years has the Individual Applicant received medical or surgical attention due to illness or injury? YES ________ NO ________

If "YES", provide details

____

Declaration – Read carefully prior to signing

I declare that I am a Canadian resident between the ages of 18 and 75. I declare that I have not, at any time during my life been diagnosed with, had any signs and/or symptoms of, or had any medical consultations and/or abnormal tests concerning any of the following:

Heart Disease	**Coronary Artery Bypass Surgery**	**Heart Valve Replacement**	**Multiple Sclerosis**
Stroke	**Paralysis**	**Brain Tumor**	**Organ Transplant**
Cancer	**Aorta Graft Surgery**	**Alzheimer's Disease**	
Kidney Disease	**Parkinson's Disease**	**Motor Neuron Disease**	

I also understand that coverage is not effective unless the Applicant's Name is specifically shown as an Insured Person with respect to this specific coverage.

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the policy wordings.

Applicant Acknowledgement

The undersigned authorized officer of the organization declares that, to the best of his/her knowledge, the statements set forth herein are true. Signing of this application does not bind the Insurer to offer, nor the Applicant to accept Insurance, but, it is agreed that this form shall be the basis of the contract should a policy be issued, and this form will be attached to and become part of the policy.

The undersigned, on behalf of the insured organization, acknowledges that any personal information provided in connection with this application (including but not limited to the information contained in this form) has been collected in accordance with applicable privacy legislation and this information shall only be used or shared by the Company to assess, underwrite and price insurance products and related services, administer and service insurance policies, evaluate and investigate claims, detect and prevent fraud, analyze and audit business results and/or comply with regulatory or legal requirements.

Applicant Name ______________________ **Title/Position** ______________

Applicant Signature ______________________ **Date** ______________

Broker Name ______________________

Broker Signature ______________________

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