APPLICATION FOR "TRANSITION"

DISABILITY INSURANCE

PLEASE PRINT OR TYPE ALL INFORMATION

PART 1

- **Transition Disability plan contains an exclusion of existing health conditions for which you have received medical attention at any time during the twelve months prior to making this Application.**

- To apply for this coverage you must submit this completed application, to Special Risk Insurance Managers Ltd., or its designated broker.

- If you become eligible for, or covered under any other Group Long Term Disability policy within a 31-day period during which you must apply for this Transition Disability Insurance, you cannot receive benefits under this insurance plan. Any premiums you have paid will be refunded.

- Coverage is only available if loss of employment is for reasons other than the Applicant's own misconduct.

- Upon approval of this Application, a Policy will be emailed to you.

1) Name (Last, First, Middle Initial)	2) Sex ❑ M ❑ F	3) Social Insurance Number
4) Home Address (Street, City, Province, Postal Code)		5) Date of Birth (MM/DD/YR)

6) Specify the monthly benefit you are applying for:

50% x Prior Salary $_____/month (max. $10,000)

7) Employer (Name and Division)	8) Date Employee Commenced with Employer
9) Total Years of Post Secondary Education or Training	10) Years of Industry Experience

11) Date Employment Terminated (MO/DD/YR)	12) Basic Monthly Earnings at Time of Termination	13) Occupation at Time of Termination
14) Reason for Termination		15) On what date did insurance terminate under your prior LTD plan?
16) Period for which insurance is being applied (max. 12 months) _____to _____		17) Period for which insurance premium is prepaid and cheque is enclosed with this Application _____to _____

The statements above are true to the best of my knowledge and belief, and I agree that they shall form a part of the contract of insurance applied for.

Dated at _____ On _____
City and Province Month Day Year

18) Applicant Signature (Individual or Corporate Representative)

_____

PART 2

Statement of Health - Participant

Participant Last Name	First Name	Middle Initial	**Birth** Place	Month	Day	Year
Home Address Number	Street	City	Province	Postal Code	**Telephone No.**	

		Yes	No
1. a)	Have you engaged in or do you intend to engage in flying as a pilot or member of the crew, racing scuba, skin or sky diving, or any other hazardous sport or activity?	❑	❑
b)	Have you ever suffered from AIDS or and AIDS - related complex, or had a positive reaction to a test designed to reveal the presence of the human immunodeficiency virus (HIV)?	❑	❑
c)	Have you ever had any life or health application declined, modified, or postponed?	❑	❑
d)	Have you applied for, or do you intend to apply for, personal disability coverage of any kind with another carrier?	❑	❑

If so, please provide:

Effective Date: _____ Insurer: _____

Date of Application: _____ Amount of Coverage: _____

2. Have you ever had any indication of or been treated for any of the following:

	Yes	No		Yes	No		Yes	No
Alcoholism or drug addiction?	❑	❑	Diabetes?	❑	❑	Kidney or urinary tract disorder?	❑	❑
Arthritis or rheumatism?	❑	❑	Epilepsy or brain disorder?	❑	❑	Lung or respiratory disorder?	❑	❑
Back, neck or spinal disorder?	❑	❑	Genital organs disorder?	❑	❑	Mental or nervous disorder?	❑	❑
Blood or glandular disorder?	❑	❑	Heart disorder?	❑	❑	Stomach, intestine or liver disorder?	❑	❑
Cancer or tumor?	❑	❑	High blood pressure?	❑	❑	Vein or artery disorder	❑	❑

		Yes	No
3.	Do you suffer from any physical abnormality, deformity, or disease not mentioned above?	❑	❑
4. a)	In the past 5 years, have you sustained any accident or injury?	❑	❑
b)	In the past 2 years, have you consulted any physician, undergone any examination or test, or received any treatment?	❑	❑
c)	In the past 6 months, have you been absent from work due to illness or injury for more that 14 days?	❑	❑
d)	Are you currently under medical care or attendance, taking drugs, following a prescribed diet, or awaiting any therapy or treatment?	❑	❑

5. Indicate your height and weight: Height: _____ cms/ft.in. Weight: _____ kgs/lbs.

6. For all "Yes" answers to questions nos. 1, 2, 3, and 4, please give complete details below:

Question No.	***Nature, Date and Duration of Disease or Injury***	***Treatment/Results***	***Names and Addresses of Doctor and Hospitals***

Name of Your Personal Doctor	***Date: Last Visit***	***Reason & Result***	***Address***

Declaration and Authorization: I the undersigned declare that:

1. The above statements and answers are true and complete and form the basis on which the insurance coverage is to be issued;
2. I understand and agree that, in case of any false statement or material omission, the insurer will not be liable under any insurance issued pursuant to the acceptance of my application;
3. I authorize any physician and other health practitioner, any hospital, clinic and other medical or paramedical organization, any insurer, the Medical Information Bureau, as well as any other person or legal entity who has information on me, or on my health condition, or who has access to such information, to divulge same to Special Risk Insurance Managers Ltd., any attorney designated to that effect, or their reinsurers. I expressly waive, on behalf of myself and of any person who shall have or claim any interest in any insurance certificate issued hereunder, all provisions of law forbidding the disclosure of such facts or information. Any copy or photographic copy of this authorization shall be as valid as the original.

Witness	Date	Signature of Participant