ALLSTATE INSURANCE COMPANY OF CANADA (AICC)

27 ALLSTATE PARKWAY, SUITE 100
MARKHAM, ONTARIO, L3R 5P8

ENROLMENT AND EVIDENCE OF INSURABILITY FORM

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks:	This box for AICC Home Office use only

GENERAL INFORMATION

Employee's Name (Surname, First, M.I.)		Employee ID Number	☐ M ☐ F
Number and Street	City	Province	Postal Code

Date of Birth	Phone Number	Email

Employer/Association/Union	Date Hired	Occupation	Plant Or Division

Primary Beneficiary's Full Name, Number and Street	City	Province	Postal Code	Relationship

Phone Number	Date of Birth

Contingent Beneficiary's Full Name, Number and Street	City	Province	Postal Code	Relationship

Phone Number	Date of Birth

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Surname	First Name	Relationship	Gender	Date of Birth	Tobacco Use*
		Employee			☐ Yes ☐ No
		Spouse			☐ Yes ☐ No

***In the past 12 months, have you used any form of tobacco, nicotine products, or substitutes (including the nicotine patch or gum)?**

Are you changing existing coverage due to a qualifying event such as marriage, birth, or adoption?
Critical Illness ☐ Yes ☐ No
If "Yes", please complete the following: Qualifying Event _____
Date of Qualifying Event _____ Current Certificate Number(s) _____

Premium/Billing Mode ☐ Monthly ☐ Semi-monthly Date of First Deduction _____ Coverage Effective Date _____	Account Number	Province

SELECTION OF COVERAGE

(Answer Yes or No and complete for each coverage selected)

Critical Illness ☐ Yes ☐ No ☐ SI	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Total Mode Premium $ _____	**Home Office Use Only**

☐ Essential Plan	☐ Comprehensive Plan	☐ 2nd Event Critical Illness Benefit	☐ 2nd Evaluation Benefit Rider

Basic Benefit Amount $ _____
If covered, Basic Benefit Amount for spouse or other dependents is 50% of the employee's.

ENROLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

Eligibility Question		EE	SP	CH
Essential Plan & Comprehensive Plan	**1.** Is any person to be insured actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Y ☐ N	N/A	N/A
If any of the questions below are answered "yes", please list the required health history in Question 7 below.				
Underwriting Questions		**EE**	**SP**	**CH**
Essential Plan & Comprehensive Plan	**2.** Has any person to be insured, in the last 10 years, been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Essential Plan & Comprehensive Plan	**3.** Has any person proposed for coverage been diagnosed, treated, or counseled in the last 5 years for any of the following? • Any disorder of the kidneys, lungs, pancreas and/or liver • Any heart condition or heart attack • Stroke or Transient Ischemic Attack (TIA) • Any medical or surgical procedures advised or recommended by a member of the medical profession but not done at this time? • More than one systolic blood pressure reading higher than 150 or more than one diastolic blood pressure reading more than 100? • Any cancer • Parkinson's Disease • Alzheimer's Disease, dementia, senility, or organic brain syndrome	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Comprehensive Plan	**4.** Has any person proposed for coverage been diagnosed, treated, or counseled in the last 5 years for any of the following? • Central Nervous System Disease or disorder (to include Multiple Sclerosis) • Chronic Fatigue Syndrome • Diabetes • Heart Disease • Macular degeneration, glaucoma, optic neuritis or cataracts • Lupus • Fibromyalgia • Emphysema • Paralysis • Rheumatoid Arthritis • An average hearing threshold sensitivity for air conduction of 40 decibels or greater	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Essential Plan & Comprehensive Plan	**5.** Indicate Height and Weight: Employee — Height: Weight: Spouse — Height: Weight: Child — Height: Weight:			
Critical Illness (over $50,000)	**6.** Provide the names and addresses of all physicians (or other members of the medical profession) for each person to be insured; the required health history section may be used if additional space is needed.			
Required Health History	**7.** Provide health history for any "Yes" answers to the Underwriting questions. Include physician's (or other members of the medical profession) name, address and telephone number:			

ENROLMENT AND EVIDENCE OF INSURABILITY FORM

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance, including all documents accompanying my certificate(s) of insurance. If electronically delivered, I understand that I will receive instructions at the email address I have provided on how to receive my certificate and accompanying documents.

☐ Yes ☐ No

By checking the "Yes" box, I elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) of insurance, to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive instructions at the last email address I have provided on how to receive correspondence.

☐ Yes ☐ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 5.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my certificate(s) of insurance, free of charge, by calling toll-free: 1-844-455-6255; or by writing to: Allstate Benefits, 49 Industrial Drive, Elmira, Ontario, N3B 3B1.

REPRESENTATION. I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. **UNDERSTANDING**. I understand that: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the “effective date” for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, Allstate Insurance Company of Canada (AICC) will refund any deductions it receives. I also understand that no producer has authority to waive any answer or otherwise modify this application, or to bind AICC in any way by making any promise or representation that is not set out in writing in this application. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof. **PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA.** 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 information or records regarding me to release to and exchange with AICC, their respective authorized plan administrators, representatives and/or producers, any and all information necessary for any or all of the following purposes: to underwrite my application for group insurance coverage, evaluate my eligibility for such coverage and adjudicate claims (“Purposes”). I authorize the release of information obtained during the underwriting process by AICC to my personal physician and to any reinsurers of my insurer(s), and when required to Public Health Authorities. I further authorize AICC, their respective plan administrators, representatives and/or producers to request I undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for the Purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of this application. I acknowledge that any information obtained from any paramedical or medical examination, any medical 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 my coverage. This authorization applies to any dependent(s) on whom insurance is requested, and I confirm that I am authorized to act on behalf of my dependent(s). This authorization shall remain valid unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Signed at: City/Province _____ Date Signed _____

Signature of Proposed Insured _____