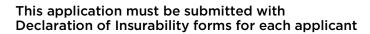
Application for Optional Life Insurance





General information

Group no.	Group name	
Division no.	Division name	
Certificate no.	Plan member's last name	Plan member's first name
Request Optional Life Insuranc	e	
Currently insured for \$	Applying for \$	Total amount requested \$
during the past 12 months. It is understo a position to meet the requirements the	ood that the insurer may periodically require	cigarettes, cigars, cigarillos, pipes, or any drugs confirmation of non-smoker status. I must be in hin 30 days of the request, failing which I shall date of the insurer's request.
\square I declare that I am a smoker.		
render the coverage as null and void. I a insuring company and People Corporative required to administer this program and	authorize my employer to deduct the require ion to receive and maintain health and claims d adjudicate claims. I understand that the in	d that any incomplete or false statements will d premiums from my payroll. I authorize the s information, as well as any other information suring company and People Corporation have the osts directly related to the recovery of such funds.
Plan member's signature		Date signed (DD/MM/YYYY)
Request Optional Life Insuranc	e for a spouse	
Spouse's last name	Spouse's first name	Date of birth (DD/MM/YYYY) Gender
Currently insured for \$	Applying for \$	Total amount requested \$
during the past 12 months. It is understo a position to meet the requirements the lose non-smoker status and the associa	ood that the insurer may periodically require in in force and to return the confirmation wit	cigarettes, cigars, cigarillos, pipes, or any drugs confirmation of non-smoker status. I must be in hin 30 days of the request, failing which I shall date of the insurer's request. I also acknowledge
\square I declare that I am a smoker.		
render the coverage as null and void. I a claims information, as well as any other	authorize the insuring company and People Co information required to administer this prog on have the right to recover any payments ma	d that any incomplete or false statements will orporation to receive and maintain health and ram and adjudicate claims. I understand that the ade in error or as a result of fraud, as well as any
Spouse's signature		Date signed (DD/MM/YYYY)
I certify that I am authorized to disclose and receive information about my spouse, and I authorize my employer to deduct the required premiums from my payroll.		
Plan member's signature		