Application for Optional Life Insurance

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This application must be submitted with Declaration of Insurability forms for each applicant

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 Insurance

Currently insured for $	Applying for $	Total amount requested $

☐ I declare that I do not smoke and have not smoked any tobacco products such as cigarettes, cigars, cigarillos, pipes, or any drugs during the past 12 months. It is understood that the insurer may periodically require confirmation of non-smoker status. I must be in a position to meet the requirements then in force and to return the confirmation within 30 days of the request, failing which I shall lose non-smoker status and the associated premium reduction shall cease as of the date of the insurer's request.

☐ I declare that I am a smoker.

I declare that the statements I have made on this application are true and understand that any incomplete or false statements will render the coverage as null and void. I authorize my employer to deduct the required premiums from my payroll. I authorize the insuring company and People Corporation to receive and maintain health and claims information, as well as any other information required to administer this program and adjudicate claims. I understand that the insuring company and People Corporation have the right to recover any payments made in error or as a result of fraud, as well as any costs directly related to the recovery of such funds.

Plan member's signature	Date signed (DD/MM/YYYY)

Request Optional Life Insurance 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 $	

☐ I declare that I do not smoke and have not smoked any tobacco products such as cigarettes, cigars, cigarillos, pipes, or any drugs during the past 12 months. It is understood that the insurer may periodically require confirmation of non-smoker status. I must be in a position to meet the requirements then in force and to return the confirmation within 30 days of the request, failing which I shall lose non-smoker status and the associated premium reduction shall cease as of the date of the insurer's request. I also acknowledge that a false or incomplete statement may cause the coverage to be null and void.

☐ I declare that I am a smoker.

I declare that the statements I have made on this application are true and understand that any incomplete or false statements will render the coverage as null and void. I authorize the insuring company and People Corporation to receive and maintain health and claims information, as well as any other information required to administer this program and adjudicate claims. I understand that the insuring company and People Corporation have the right to recover any payments made in error or as a result of fraud, as well as any costs directly related to the recovery of such funds.

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	Date signed