

APPLICATION FORM

Advance Payment of Group Life Insurance

PART I - EMPLOYER'S STATEMENT

Group Policy No: 20570 _____ 33383 _____

Name of Insured _____

Address _____ City _____

Province _____ Postal Code _____

Date of Birth _____ Date Last Worked _____

Salary as of Last Day Worked \$ _____ Occupation _____

Total Amount of Basic Life Insurance Coverage \$ _____

The amount of advance available will be up to 50% of the above Basic Life Insurance coverage to a maximum of \$50,000.

PART II - INSURED EMPLOYEE'S AUTHORIZATION

To be eligible for this advance, you must be suffering from a terminal illness and have a life expectancy of 24 months or less.

I request an advance of \$ _____

Your physician must complete the Attending Physician's Statement.

Authorization: I expressly consent, authorize and direct any physician, surgeon or any other person who has examined me, and every hospital or other institution where I have received treatment, to disclose to the insurance company or its duly authorized representative any knowledge or information thereby required. A photocopy of this authorization shall be as valid as the original.

Date

Signature

FOR CHR USE ONLY. I authorize the release of an advance payment of basic life insurance proceeds outside of the terms of the Group Policy.

Date

Signature and Official Title