CHUBB®

GROUP INSURANCE PLAN
VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT ENROLLMENT FORM

GROUP POLICY INFORMATION

Policyholder Name: Fellowship of Evangelical Baptist Churches in Canada	**Policy #: OE50043601**

EMPLOYEE INFORMATION

Last Name:	**First Name:**		
Date of Birth:	**Telephone #: ( )**		
Address - Street:	**City:**	**Province:**	**Postal Code:**

DEPENDENT INFORMATION

	Last Name	First Name	Birthdate (D/M/Y)	Dependent Children (< age 21)	Full-Time Student (< age 25)	Disabled Dependent (> age 21)
Spouse						
Child				☐	☐	☐
Child				☐	☐	☐
Child				☐	☐	☐

COVERAGE SELECTION

Principal Sum Selection:	**$**	
Coverage Type:	☐ **Employee Only Plan OR**	☐ **Family Plan**
Monthly Premium* you will pay:	**$**	**$**

***Please refer to the Voluntary Accidental Death & Dismemberment Insurance summary page for the monthly premium rates.**

BENEFICIARY DESIGNATION

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the Policy. Failing such designation, all benefits will be paid to the Estate of the Insured Person.

I hereby name the following revocable beneficiary (Irrevocable in the province of Quebec) for for any Life and/or Accidental Death and Dismemberment Insurance benefits payable as a result of my participation in this plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid.

Please Note: In the province of Quebec, if you have designated your married or civil union spouse as beneficiary, the designation will be considered irrevocable unless you check here: ☐ Revocable.

I hereby make the beneficiary designation below; I may elect to change this beneficiary designation at any time.

Name of Beneficiary	Relationship to Insured	Percentage

Complete this section if a beneficiary named on this form is a minor. If so, you agree that any benefit that becomes payable to a minor child will be paid to the trustee to hold in trust for the child until the child comes of age.

Name of Trustee	Relationship to Minor Beneficiary

I wish to appoint the following contingent beneficiary(ies) in the event my primary beneficiary predeceases me.

Name of Contingent Beneficiary	Relationship to Insured	Percentage

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PRIVACY STATEMENT

At Chubb Life, we are committed to protecting our customers' privacy. Chubb Life's policy is to limit access to customer information to those who need it to serve customers' insurance needs and to maintain and improve customer service. The information provided by customers is required by us, our reinsurers and authorized administrators to assess customers' entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, we, our reinsurers and authorized administrators consult existing insurance files about customers, collect additional information about and from customers, and where required, collect information from and exchange information with, third parties. We do not disclose customer information to third parties other than our agents and brokers, except as necessary to conduct business, e.g., processing claims or as required by law. We advise customers that, in some instances, employees, service providers, agents, reinsurers, and any of their providers, of Chubb and/or Chubb Life may be located in jurisdictions outside Canada and that customers' personal information may thus be subject to the laws of those foreign jurisdictions.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

AUTHORIZATION

I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb and/or Chubb Life, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Signed at _____ **this** _____ **day of** _____ **20** _____

_____ _____

Employee's Signature | Spouse's Signature (if applicable)

Information about your insurability and your dependents insurability will be treated as confidential.