CHUBB®

GROUP INSURANCE PLAN
VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT ENROLLMENT FORM

GROUP POLICY INFORMATION

Policyholder Name: Alberta Medical Association	**AMA Member #:**	**Policy #: OE50092201**

MEMBER INFORMATION

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

SPOUSAL INFORMATION (only complete if Member & Family Plan Selected):

Last Name:	**First Name:**	**DOB:**

COVERAGE SELECTION

Principal Sum Selection (Maximum $1,000,000):	**$**	
Coverage Type:	◯ **Member Only Plan**	◯ **Member & Family Plan**
Monthly Premium you will pay:	**$0.50/month/$50,000**	**$1.00/month/$50,000**

BENEFICIARY DESIGNATION

All benefit payments, including benefits payable for any insured dependent child covered under this plan, if applicable are paid directly to you. If you are deceased at the time that a benefit becomes payable, we will pay benefits to the beneficiary you named below. If you do not designate a beneficiary benefits will be paid to your Estate.

I appoint the following revocable beneficiary for Insurance benefits payable as a result of 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.

	Full Legal Name	**Relationship to Insured (or minor for Trustee)**
Primary Beneficiary		
Contingent Beneficiary		
Trustee (for minor beneficiary)		

REQUEST FOR PRE-AUTHORIZED PAYMENT PLAN (Please attach a VOID cheque) ☐ Monthly ☐ Annual

Bank	Account Number		
Bank Number	Branch Number		
Address	City	Province	Postal Code

I/we authorize the Alberta Medical Association ("AMA") and the financial institution designated to begin deduction of premium for the AMA Voluntary AD&D Insurance in the amount based on the benefit selection made by me above, to be charged on or about the first business day of each month/year to the account. I have waived the right to pre-notification at least 10 days before my first PAD; however the Alberta Medical Association will send me written notice identifying the new amount at least 10 days before each and any change in the amount of my PAD, with the exception of a reduction in tax rate. I may revoke my authorization at any time in writing or by phone, subject to a 30 day notice. To obtain a sample cancellation form or for information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca. I have certain recourse rights if any PAD does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

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 hereby apply for coverage under the Alberta Medical Association Group Insurance Plan, underwritten by Chubb Life Insurance Company of Canada, for which I am eligible. I certify that the information provided herein is true, accurate and complete.

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

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Member's Signature