

EDMONTON PIPE INDUSTRY L.U. #488

16214 - 118 Avenue, Edmonton, AB T5V 1M6
Phone (780) 452-1331

MANULIFE FINANCIAL POLICY #4021 APPLICATION KIT - OPTIONAL GROUP LIFE

★ BENEFICIARY DESIGNATION

★ APPLICATION FOR OPTIONAL LIFE

Questions #2 through #6 - to be completed by the Plan Member

NOTE: Under the terms of this plan, a "non-smoker" is defined as having abstained from smoking for at least the past 12 consecutive months prior to the application for the Optional Life program.

★ GROUP BENEFITS EVIDENCE OF INSURABILITY

- to be completed for each person applying for insurance

★ MONTHLY PREMIUM RATE TABLE

★ RATE CALCULATION WORKSHEET

★ GENERAL PLAN PROVISIONS

➤ *Please return the Beneficiary Designation page along with the Application for Optional Life and the Group Benefits Evidence of Insurability forms*

ATTN: WANDA
EDMONTON PIPE INDUSTRY
16214 - 118 AVENUE
EDMONTON, AB T5V 1M6

➤ *After processing, (4 to 6 weeks) we will send a letter stating approval or denial. If approved, we will inform you of payments required.*

➤ *If you have any questions, please call Wanda at (780) 452-1331 Ext. 269*

EDMONTON PIPE INDUSTRY L.U. #488

16214 - 118 Avenue, Edmonton, AB T5V 1M6
Phone (780) 452-1331

MANULIFE FINANCIAL #4021

BENEFICIARY DESIGNATION

Member Name _____ Male _____ or Female _____
Address _____ Birth Date _____
City & Province _____ S.I.N. _____
Postal Code _____ Phone (____) _____

BENEFICIARY (for Member coverage only)

Name _____ Relationship _____

* Beneficiary for spouse/dependent coverage will automatically be the "member".

* I understand that if my designated beneficiary does not survive me, settlement under the Policy will be made to my Estate.

AMOUNT OF BENEFIT (Refer to Monthly Premium Rate Table)

MEMBER \$ _____

SPOUSE \$ _____

DEPENDENT CHILDREN \$ _____

SIGNATURES

MEMBER

DATE

EPI AUTHORIZED REPRESENTATIVE

DATE

Group Benefits

Application for Optional Life Insurance for Plan Member and Dependents

INSTRUCTIONS - Please print all answers

- Please consult your plan administrator for type of coverage available under your plan. Check (✓) the appropriate box to indicate the type of coverage for which you are applying.
 PLAN MEMBER ONLY PLAN MEMBER AND SPOUSE PLAN MEMBER, SPOUSE AND DEPENDANTS SPOUSE AND/OR DEPENDANTS
- Please ensure that ALL SECTIONS are completed.
 Section 1 - Plan sponsor's information - **TO BE COMPLETED FIRST BY PLAN ADMINISTRATOR.**
 Sections 2, 3, 4, 5 and 6 - Plan member's information - To be completed by plan member and submitted to Manulife Financial.
- This application **MUST BE** submitted to Manulife Financial with a **COMPLETED** Evidence of Insurability form (GL0004E). (Evidence of Insurability is **NOT** required if changing status from "Smoker" to "Non-smoker".)
- If required, retain a photocopy for your files.

| | | | | |
|--|--|--|---|-------|
| 1 Plan sponsor's information | Plan contract number(s) | Division number | Plan member certificate number | |
| | | | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Class</td> <td style="width: 30%;">Annual earnings \$</td> </tr> </table> | Class |
| Class | Annual earnings \$ | | | |
| | Plan sponsor | Eligibility date (dd/mmm/yyyy) | | |
| Optional life amount: | | | | |
| | Plan member's present amount of optional life | \$ _____ OR _____ units of \$ _____ OR _____ x salary | \$ _____ = \$ _____ | |
| | Additional amount requested | \$ _____ OR _____ units of \$ _____ OR _____ x salary | \$ _____ = \$ _____ | |
| | Total amount requested | \$ _____ OR _____ units of \$ _____ OR _____ x salary | \$ _____ = \$ _____ | |
| Spousal optional life amount: | | | | |
| | Spouse's present amount of optional life | \$ _____ OR _____ units of \$ _____ OR _____ x salary | \$ _____ = \$ _____ | |
| | Additional amount requested | \$ _____ OR _____ units of \$ _____ OR _____ x salary | \$ _____ = \$ _____ | |
| | Total amount requested | \$ _____ OR _____ units of \$ _____ OR _____ x salary | \$ _____ = \$ _____ | |
| Dependant optional life amount: | | | | |
| | Dependant's present amount of optional life | \$ _____ OR _____ units of \$ _____ | | |
| | Additional amount requested | \$ _____ OR _____ units of \$ _____ | | |
| | Total amount requested | \$ _____ OR _____ units of \$ _____ | | |
| | Plan administrator name | Date signed (dd/mmm/yyyy) | | |
| | Phone number | Email address | | |
| 2 Plan member's information | Plan member's name (last, first and middle initial) | | Date of birth (dd/mmm/yyyy) | |
| | Language preference/Langue préférée <input type="radio"/> English/Anglais <input type="radio"/> French/Français | Sex <input type="radio"/> Male <input type="radio"/> Female | Province of residence | |
| | Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? <input type="radio"/> Yes <input type="radio"/> No | | | |

Please complete both pages of this form.

3 Beneficiary designation information

If a beneficiary is not assigned, "ESTATE" will be assumed.

| | |
|---|-----------------------------|
| Name of beneficiary (last, first and middle initial) | Relationship to plan member |
| Additional name, if applicable (last, first and middle initial) | Relationship to plan member |
| Additional name, if applicable (last, first and middle initial) | Relationship to plan member |

For designated beneficiaries under the age 18.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of 18.

Irrevocability

For Quebec residents only
In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified.

If spouse is beneficiary, designation is:

Revocable Irrevocable

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

4 Spousal coverage

Note: you will be the beneficiary of your spouse's insurance, if you are then living, otherwise the beneficiary will be your estate.

| | | |
|---|--|-----------------------------|
| Spouse's name (last, first and middle initial) | Sex <input type="radio"/> Male <input type="radio"/> Female | Date of birth (dd/mmm/yyyy) |
| Has your spouse smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? <input type="radio"/> Yes <input type="radio"/> No | | |

5 Dependant coverage

Note: you will be the beneficiary of your dependant's insurance, if you are then living, otherwise the beneficiary will be your estate.

| | |
|---|--|
| Dependant's name (last, first and middle initial) | Date of birth (dd/mmm/yyyy) |
| Relationship to plan member | Student status full time student <input type="radio"/> Yes <input type="radio"/> No |

6 Plan member's information

Certification and authorization

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by Manulife. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

| | |
|---|--------------------|
| Plan member's signature | Date (dd/mmm/yyyy) |
| Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form) | Date (dd/mmm/yyyy) |

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

7 Mailing instructions

Please send the completed form to:

**Group Medical Underwriting
Manulife Financial
PO BOX 2026
HALIFAX NS B3J 2Z1**

Group Benefits Evidence of Insurability

Please complete this form **only** if you are purchasing optional life for the first time or if you are increasing your current long term disability or optional life coverage.

1 Plan member information

To be completed by the plan member.

| | | | | |
|--|---------------------|---|--|---|
| Plan sponsor name Edmonton Pipe Industry | | Plan contract number 4021 | Division name (if appropriate) | |
| Plan member name (first, middle initial, last) | | Height _____ m _____ cm _____ ft _____ in | Weight <input type="radio"/> kg <input type="radio"/> lb | Sex <input type="radio"/> Male <input type="radio"/> Female |
| Plan member certificate number | Annual Salary \$ | Hire date (dd/mmm/yyyy) | | Occupation |
| Smoking status declaration Have you used any form of tobacco or cannabis within the last twelve months? <input type="radio"/> Yes <input type="radio"/> No | | | | |
| Plan member address (street number, street, apartment) | | | | |
| City | | Province | Postal code | |
| Date of birth (dd/mmm/yyyy) | Place of birth | Home telephone number () | Business telephone number () | |
| Regular physician name | | Physician address | | Date/reason for last consultation |

| Coverage being applied for: | Existing amount of coverage or option (if applicable) | Total amount of coverage or option requested |
|---|---|--|
| <input type="radio"/> Long Term Disability | | |
| <input type="radio"/> Optional life – plan member | | |
| <input type="radio"/> Optional life – spouse | | |
| <input type="radio"/> Optional life – dependant | | |

| This section to be completed by Manulife Financial. | Existing amount of coverage or option (if applicable) | Total amount of coverage or option requested | NEM |
|---|---|---|-----|
| <input type="radio"/> Basic life | | | |
| <input type="radio"/> Late entrant | <input type="radio"/> Single <input type="radio"/> Family | <input type="radio"/> Dependant <input type="radio"/> Other _____ | |
| <input type="radio"/> Other _____ | | | |

Is plan member actively at work? Yes No

Benefits administrator signature _____ Date signed (dd/mmm/yyyy) _____

2 Dependant information

(If applying for spousal/dependant coverage)

| | | | | |
|--|-----------------------------|---|--|---|
| Spouse name (first, middle initial, last) | | Height _____ m _____ cm _____ ft _____ in | Weight <input type="radio"/> kg <input type="radio"/> lb | Sex <input type="radio"/> Male <input type="radio"/> Female |
| Smoking status declaration Have you used any form of tobacco or cannabis within the last twelve months? <input type="radio"/> Yes <input type="radio"/> No | | | | |
| Address (street number, street, apartment) | | | | |
| City | | Province | Postal code | |
| Date of birth (dd/mmm/yyyy) | Place of birth | Home telephone number () | Business telephone number () | |
| Child name (first, middle initial, last) | Date of birth (dd/mmm/yyyy) | Height _____ m _____ cm _____ ft _____ in | Weight <input type="radio"/> kg <input type="radio"/> lb | Sex <input type="radio"/> Male <input type="radio"/> Female |
| Child name (first, middle initial, last) | Date of birth (dd/mmm/yyyy) | Height _____ m _____ cm _____ ft _____ in | Weight <input type="radio"/> kg <input type="radio"/> lb | Sex <input type="radio"/> Male <input type="radio"/> Female |
| Spouse/dependant regular physician name | | Physician address | | Date/reason for last consultation |

The approval process is subject to delays depending on the length of time to arrange required examinations and/or for physicians to complete and forward required information to Manulife Financial. You can speed up this process by being available for required examinations at the earliest possible date and/or by asking your physician to provide required information in a timely fashion.

If you have more than two children, please attach separate sheet (signed and dated) and include all personal information as requested above.

(Please complete all pages of this form and ensure it is signed and dated.)

3 Medical questions for proposed insured

COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES QUESTIONS. If you require more room for YES answers please attach a separate sheet (signed and dated).

| | Plan member | Spouse | Children |
|---|--|--|--|
| 1. Do you currently participate in any hazardous sport activity, such as SCUBA diving, piloting aircraft, auto racing, etc.? Please specify which activity: _____ | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| 2. Have you | | | |
| (a) ever applied for or received benefits, compensation or pension because of sickness or injury? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (b) ever had an application for life or health insurance declined, postponed, or modified in any way? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (c) been absent from work for medical reasons during the last 5 years? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (d) are you currently receiving any treatment? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (e) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (f) any family history of any inherited or familial disease (e.g. Huntington's Chorea, diabetes, heart or kidney disease)? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| 3. Have you ever consulted a physician, ever been treated for, or had any known identification of | | | |
| (a) chest pain, blood vessel disease, heart disorder, or heart attack? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (b) high blood pressure, stroke? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (c) allergies or skin disorders, including growths, cysts or tumours? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (d) glandular disorders, including thyroid disorders and diabetes? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (e) epilepsy, nervous or mental illness, or an emotional condition such as anxiety or depression? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (f) excessive use of alcohol or drugs? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (g) lung disorders? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (h) bowel disorders, stomach or liver disorders? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (i) cancer? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (j) disorder of the kidney, urine or genital organs? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (k) arthritis or rheumatism? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (l) disorders of the muscles or bones including the back, spine or joints? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (m) immune deficiency disorder including AIDS or AIDS-related complex (ARC), or any generalized enlargement of the lymph glands, or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (n) anemia, or other blood disorders? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| 4. Have you ever had any physical impairment, condition, disease or disorder, or chronic symptoms not covered above? | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |

Please provide details below, if you have answered "Yes" to ANY questions. If more space is needed, use another form or sheet of paper (both must be signed and dated).

| Question number | Name of person (first & middle) | Details or name of condition | Date and duration | Treatment and results (recovery or remaining effects) | Names and addresses of physicians and hospitals |
|-----------------|---------------------------------|------------------------------|-------------------|---|---|
| | | | | | |
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4 Declaration and authorization

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this Group Benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. **I agree** that my coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in this application. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). **I am authorized** to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child. **I understand** that Manulife may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by Manulife. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

| | |
|---|---------------------------|
| Signature of plan member | Date signed (dd/mmm/yyyy) |
| Signature of spouse (required only if evidence regarding insurability of spouse is provided in this form) | Date signed (dd/mmm/yyyy) |

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

5 Mailing instructions

Mail all Evidence of Insurability forms to:

**Edmonton Pipe Industry
16214-118 AVENUE
EDMONTON AB T5V 1M6**

EDMONTON PIPE INDUSTRY L.U. #488

MANULIFE FINANCIAL #4021 OPTIONAL GROUP LIFE

MONTHLY PREMIUM RATE TABLE

I) COVERAGE FOR ELIGIBLE MEMBERS

RATES PER \$10,000 UNIT OF BENEFIT

| MEMBER ATTAINED AGE | MEMBER SMOKER | MEMBER NON-SMOKER |
|---------------------|---------------|-------------------|
| Up to age 30 | 0.90 | 0.60 |
| 31 - 35 | 1.00 | 0.70 |
| 36 - 40 | 1.30 | 0.80 |
| 41 - 45 | 2.30 | 1.30 |
| 46 - 50 | 3.60 | 2.00 |
| 51 - 55 | 6.30 | 3.50 |
| 56 - 60 | 9.90 | 6.00 |
| 61 - 64 | 13.40 | 8.10 |
| 65 - 69 | 21.00 | 12.30 |

*MAXIMUM 10 units of coverage per eligible member

I) COVERAGE FOR ELIGIBLE DEPENDENTS

- a. Spouse - covered for 10% of member's insured amount
- b. Dependent child(ren) - each dependent child covered for 5% of members insured (included in rates).

RATES PER \$1,000 of spousal coverage

| SPOUSE ATTAINED AGE | SPOUSE SMOKER | SPOUSE NON-SMOKER |
|---------------------|---------------|-------------------|
| Up to age 30 | 0.16 | 0.14 |
| 31 - 35 | 0.17 | 0.15 |
| 36 - 40 | 0.20 | 0.16 |
| 41 - 45 | 0.24 | 0.19 |
| 46 - 50 | 0.33 | 0.26 |
| 51 - 55 | 0.55 | 0.35 |
| 56 - 60 | 0.78 | 0.50 |
| 61 - 64 | 1.11 | 0.78 |
| 65 - 69 | 1.65 | 1.07 |

EDMONTON PIPE INDUSTRY L.U. #488

MANULIFE FINANCIAL LIFE #4021 OPTIONAL GROUP LIFE

RATE CALCULATION WORKSHEET

A) **MEMBER** Attained Age _____
 Smoker Yes / No
 # of Units _____
 X Rate per Unit _____
 = Monthly Premiums \$ _____

B) **SPOUSE** Attained Age _____
 Smoker Yes / No
 # of Units _____
 X Rate per Unit _____
 = Monthly Premiums \$ _____

TOTAL MONTHLY PREMIUM \$ _____

NOTE: This automatically covers each eligible dependent child for a benefit equal to 5% of the member's benefit.

AMOUNT OF COVERAGE

- MEMBER \$ _____ (100%)
- SPOUSE \$ _____ (10% if applicable)
- EACH CHILD \$ _____ (5% if applicable)

EDMONTON PIPE INDUSTRY L.U. #488

MANULIFE FINANCIAL #4021

GENERAL PLAN PROVISIONS

ELIGIBILITY FOR COVERAGE

All members in good standing with the Edmonton Pipe Industry L.U. #488 are eligible to participate in the Optional Group Life program, provided they have not yet attained the age of 70 years.

The spouse of an eligible member will be eligible for Dependent Spousal coverage provided that neither the member nor the member's spouse has yet attained the age of 70 years.

A dependent child of an eligible member will be eligible for Dependent child coverage provided such child has attained the age of 14 days, but has not yet attained the age of 19 years. (For purposes of this coverage, a dependent child will be deemed still eligible for coverage if he/she is attending an educational institute on a **full-time** basis, and has not yet attained the age of 26 years.)

EVIDENCE OF INSURABILITY

Satisfactory evidence of insurability would be required from all applicants into the Optional Life program. Based on the results of the Medical Questions, evidence may be required, at the insurer's expense.

All covered persons requesting an increase in insured benefit amounts would be required to submit satisfactory evidence of insurability.

AGE LIMITATIONS

All insured benefit amounts will terminate on attainment of the covered person's age 70; or if an approved premium waiver claimant, coverage would terminate automatically on attainment of age 65.

SUICIDE PROVISION

The Optional Life benefit does not include, and no payment shall be made for, loss of life resulting from any injury caused or contributed by, or as a consequence of, suicide or any attempt thereat (whether sane or insane), or intentionally self-inflicted injury unless the employee has been insured under the plan for at least 24 consecutive months; or, in the case of an increase in the amount of an employee's insurance, no payment with respect to such increase shall be made for loss of life resulting from any injury or contributed by, or as a consequence of, suicide or any attempt thereat (whether sane or insane), or intentionally self-inflicted injury unless the employee has been insured with respect to such increase for at least 24 consecutive months.

SMOKING STATUS DECLARATION

All persons having attained age 18 or over applying for non-smoker's rates will be required to include as part of the application a "Smoking Status Declaration" included in Section 2.

UNITIZED COVERAGE LIMITS

Coverage is available to eligible members in units of \$10,000 each, subject to a maximum of 10 units per eligible member. If desired and selected, an eligible member may obtain coverage for his spouse and dependent children in accordance with the rate tables provided.

Coverage for the spouse will be equivalent to 10% of the member's insured benefit, and insured coverage for **each** dependent child will be equivalent to 5% of the member's insured coverage. (There is no maximum applicable to the number of eligible dependent children that may be covered by an insured member.)