S.G.E.U. HEALTH AND WELFARE TRUST

PORTAPLAN

TERM LIFE INSURANCE
ACCIDENTAL DEATH AND DISMEMBERMENT
YOUNG ADULT SECURITY INSURANCE
DEPENDENT LIFE INSURANCE

S.G.E.U. Health and Welfare Trust

Dear SGEU Members and Associates:

SGEU Portaplan has provided competitive comprehensive insurance coverage for our members and affiliates since 1971.

Portaplan offers the following features:

- **PROTECTION SECURITY VERSATILITY**
- Guaranteed, renewable, and convertible
- Individual policy issued
- Coverage over age 90 without further premium payments
- Portability- take it with you on leaving your Employer
- Retirement- coverage can continue for the duration of your lifetime
- Flexible- increase or decrease coverage as your needs dictate
- Waiver of premium in the event of total disability
- Generous coverage with rates substantially below market cost
- Available to eligible member, spouse, dependent children or young adult children

PORTAPLAN IS OUR PLAN: Compare Portaplan with Group, Creditor or Optional insurance coverage in light of your own needs. The plan provides quality, low-cost, very competitive, and comprehensive insurance coverage and expresses fully the concept of a good insurance plan.

We recommend Portaplan and encourage you to consider using it to provide financial protection for you and your family.

In solidarity,

Robert Bymoen
President

Roseann Strelezki
Secretary Treasurer

SASKATCHEWAN GOVERNMENT AND GENERAL EMPLOYEE'S UNION

A COMPONENT OF THE NATIONAL UNION OF PUBLIC AND GENERAL EMPLOYEES, AND AFFILIATED WITH THE SASKATCHEWAN FEDERATION OF LABOUR, AND THE CANADIAN LABOUR CONGRESS.

GENERAL INFORMATION

This brochure is designed to outline the benefits for which you are eligible and does not create or confer any contractual or other rights. All rights with respect to the benefits of an insured person will be governed solely by Group Policy and Master Agreement issued by Co-operators Life to the Saskatchewan Government and General Employees' Union. This policy and agreement are available for inspection at any reasonable time at the SGEU office.

WHO IS ELIGIBLE TO APPLY?

- Members under age 65 (including members, associate members, employees and affiliate members) of Saskatchewan Government and General Employees' Union, who are resident in Canada, actively at work and have not been absent more than 7 days in the last 60 days.
- Legal Spouses of eligible members (who are under age 65).
- Children of eligible members (see Young Adult Security benefit).

IS A MEDICAL EXAM REQUIRED?

A short statement of health and other particulars of insurability are required if you apply for Term Life Insurance. However, Co-operators Life reserves the right to request a medical examination or other evidence at no expense to you. You will be notified directly if one is required. No statement of health is required for the Accidental Death and Dismemberment or Dependent Children Life Insurance coverage.

IS THERE A GUARANTEE ISSUE BENEFIT?

During the period of May 1st to July 31st each year, new members and spouses and children of eligible members, are eligible to apply for one unit of $20,000 Term Life without any statement of health.

WHEN DOES INSURANCE TAKE EFFECT?

Insurance will take effect on the first of the month following the date the completed application is approved by The Co-operators.

WHAT PROOF OF COVERAGE WILL I RECEIVE?

After your application has been approved, you will receive a confirmation of coverage letter. This letter provides effective date and amount of coverage.

IS THIS INSURANCE PORTABLE?

Insurance may be continued provided you pay the premiums as they are due. All members must be Canadian residents in order to continue to be eligible for Insurance. Coverage cannot be increased if you are not an eligible member of SGEU.

IS MY INSURANCE GUARANTEED?

Your Insurance Policy may not be cancelled, changed nor have a renewal refused by Co-operators Life, provided you pay the required premiums as they are due.

ARE PREMIUMS WAIVED DURING DISABILITY?

Should you become totally and permanently disabled before age 65, all Term Life and Dependent Child Life premiums falling due after four months of continuous disability will be waived while disability continues. There is no extra charge for this benefit.

WHEN ARE PREMIUMS DUE?

Premium notices are sent each year prior to May 1st. Premiums are due within 60 days of the Billing Date or May 1st, whichever is later. Annual premiums can be paid in monthly installments by automatic withdrawl from the member's personal bank account. See the Payment Section for further information.

HOW TO CALCULATE YOUR PREMIUM?

The premium rates quoted in this brochure are on an annual basis. If you applied for insurance other than on a premium due date, a prorated premium will be payable. "Age" for the purposes of this plan is determined by subtracting the year and month of birth from the year and month of application. Any change in premium or insurance amounts occurs on the 1st of the month following your birth month.

WHO PROVIDES PLAN SERVICES?

If you have any questions about your insurance or require additional information, contact:

Shane Osberg
Director, Disability Management Services
SGEU
Phone: (306) 775-7204
Toll Free: 1-800-667-5221 ext. 204
Fax: (306) 775-7246
email: sosberg@sgeu.org
website: www.sgeu.org

HOW TO APPLY

Send your completed application to:

Saskatchewan Government and General Employees' Union
Portaplan Administrator
1011 Devonshire Drive North Regina, SK S4X 2X4

You will be billed for the premium once your application has been approved.

TERM LIFE INSURANCE

- Members and spouses under age 65 are eligible to apply. * Children of Members Age 16-25 - see Young Adult Security.
- Select up to 25 units of $20,000 in total at any time up to age 64.
- Coverage over age 90 without further premium payment.
- See schedule of Annual Unit Premiums.
- Insurance reduces at higher ages. See schedule of Unit Amounts.

BENEFICIARY CHANGES

Your beneficiary may be changed at any time subject to any limits set by law by completing a Plan Member Change Form GL2260.

CONVERSION PRIVILEGE

If your Term Life Insurance is cancelled before you are 66 years old, you may apply within 31 days to convert your insurance to an individual permanent plan. This may be done without further evidence of insurability and at rates applicable to your age and occupation at the time of conversion.

LIMITATIONS

Suicide within two years of the effective date of coverage is not a covered risk.

ACCIDENTAL DEATH AND DISMEMBERMENT

- Available if you are insured for Term Life Insurance.
- Select up to 25 units of $20,000 providing it doesn't exceed the Term Life amount.
- Insurance reduces at higher ages in the same way as Term Life. See schedule of Unit Amounts below.

BENEFITS PAYABLE

A percentage of benefits is payable for any of the following losses which results within 180 days of an accident causing bodily harm.

- 100% payable to your Beneficiary for loss of life.
- 100% payable to you for "loss of" or "loss of use of", both hands, both feet, both arms or both legs.
- 100% payable to you for loss of sight in both eyes, sight of one eye and one hand, sight of one eye and one foot, one hand and one foot, one arm and one leg, hearing and speech.
- 75% payable to you for "loss of use of" one arm or one leg.
- 67% payable to you for "loss of use of " one foot or one hand.
- 67% payable to you for loss of one hand and/or one foot or sight of one eye.
- 67% payable to you for loss of one hand or one foot.
- 67% payable to you for loss of hearing or speech.
- 33% payable to you for loss of thumb and index finger on the same hand.

If a member while insured under this benefit:

a) Disappears as a result of an accident involving the sinking or disappearance of a conveyance he was riding in, and if his body has not been found within 365 days of the date of such accident, it will be presumed loss of life occurred. OR;
b) Is unavoidably exposed to the elements as a result of an accident and if such exposure causes a loss for which an amount would otherwise be payable, an amount will be payable for such loss in accordance with the schedule of losses.

Payment for losses is subject to the usual exclusions, including suicide, self-inflicted injury, criminal offences, disease, armed forces, riot, war, certain non-commercial flights.

ANNUAL PREMIUM

$12.72 per unit

DEPENDENT CHILDREN

- Children of an eligible member who is insured for Term Life Insurance are eligible.
- Insures ALL eligible children.
- Children are eligible if they are over 14 days of age and under 21 years, (25 if in full time attendance at a high school, College or University and for whom you are entitled to claim a deduction for Income Tax purposes).
- If the member cease to be insured for any reason, including death, the Dependent Children Life coverage automatically terminates.
- Conversion privilege is available upon joint death of both parents.

BENEFITS PAYABLE

- In the event of death of an insured child, the benefit is paid to the member.
- Benefits payable - $5,000 per child.
- If both husband and wife are insured for Term Life Insurance, only one may apply for Dependent Children Life Insurance.

ANNUAL PREMIUM

$19.92 (insures ALL Eligible Children)

YOUNG ADULT SECURITY INSURANCE

- Children of an eligible member who are between the ages of 16 and 25 years of age are eligible to apply.
- Eligible to Apply for Term Life Insurance, Accidental Death & Dismemberment and Dependent Children Life Insurance.
- Select up to 25 units of $20,000 in total at any time up to age 25.
- Underwritten on the same basis for Term Life Insurance for members and spouses.
- See Schedule of Annual Unit Premiums below.
- Any amount of insurance payable under this Policy on the life of a Dependent shall be payable to the member.
- Any Dependent Child age 21 and over may, at any time, designate a beneficiary.

ANNUAL - UNIT PREMIUMS - TERM LIFE

Age	Unit Amount	Unisex Smoker	Unisex Non-Smoker	Age	Unit Amount	Unisex Smoker	Unisex Non-Smoker	Age	Unit Amount	Unisex Smoker	Unisex Non-Smoker
To 25	$20,000	$12.93	$5.51	69	$16,000	$354.09	$202.34	80	$5,000	$369.63	$211.21
26-30	$20,000	$14.87	$7.05	70	$15,000	$360.85	$206.19	81	$5,000	$399.56	$228.33
31-35	$20,000	$19.46	$9.30	71	$14,000	$361.81	$206.75	82	$5,000	$430.98	$246.26
36-40	$20,000	$21.09	$10.59	72	$13,000	$363.09	$207.49	83	$5,000	$464.76	$265.01
41-45	$20,000	$42.82	$17.13	73	$12,000	$390.46	$223.13	84	$5,000	$500.96	$286.26
46-50	$20,000	$64.64	$29.41	74	$11,000	$369.99	$211.43	85	$5,000	$503.46	$287.69
51-55	$20,000	$114.74	$63.08	75	$10,000	$505.66	$288.95	86	$5,000	$505.98	$289.13
56-60	$20,000	$157.51	$88.39	76	$9,000	$489.23	$279.56	87	$5,000	$508.51	$290.58
61-65	$20,000	$263.64	$145.59	77	$8,000	$470.44	$268.60	88	$5,000	$511.05	$292.03
66	$19,000	$333.80	$190.74	78	$7,000	$443.64	$253.50	89	$5,000	$513.61	$293.49
67	$18,000	$339.98	$194.21	79	$6,000	$410.90	$234.80	90	$5,000	$516.18	$294.96
68	$17,000	$348.16	$198.95								

SASKATCHEWAN GOVERNMENT AND GENERAL EMPLOYEE'S UNION

Group Policy #6821

Application for Portaplan Group Insurance

SGEU
WORKING TOGETHER FOR SASKATCHEWAN

To avoid delays, please complete the required information by printing clearly in ink.

This form must be received in our office within 90 days of the application being signed, otherwise a new application must be completed.

BENEFITS APPLIED FOR AT THIS TIME (Do not include any benefits already in force)

☐ **Guaranteed Issue Limit** . . . . . 1 Unit, $20,000

☐ **Term Life Insurance** (25 Units available) . . . . . Number of Units _____

☐ **Accidental Death and Dismemberment** (25 Units available) . . . . . Number of Units _____
(Available only if you participate in Term Life Insurance Plan)

☐ **Dependent Children Life Insurance**
(Available only if you participate in Term Life Insurance Plan & insures all eligible children)

☐ **Young Adult Security Insurance** (must be a child of a member) . . . . . Number of Units _____

APPLICANT INFORMATION

Life Proposed: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____ (Firstname) _____ (Initial) _____ (Lastname)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Employer _____ Occupation _____

Date of Birth _____ (MMM/DD/YYYY) Telephone (_____) _____ Status: ☐ Member ☐ Spouse ☐ Young Adult

Is Life Proposed now insured under this plan? ☐ Yes ☐ No If Yes, provide Policy Number _____

Billing Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Beneficiary in the event of death of the Life Proposed _____ (Firstname) _____ (Initial) _____ (Lastname)

Relationship to Life Proposed _____

APPLICANT DECLARATION OF INSURABILITY

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke? . . . . . ☐ Yes ☐ No
   If yes, specify _____

2. Have any of your parents, brothers or sisters had any hereditary disorders? . . . . . ☐ Yes ☐ No
   If yes, specify (ie: Huntington's chorea, polycystic kidney disease, etc.) _____

3. Have you had any symptoms of, or treatment for, any medical condition, disorder or ailment that resulted in your hospitalization within the last 2 years? . . . . . ☐ Yes ☐ No
   If yes, give details below:

Name of Disorder	Date of Onset (MMM/DD/YYYY)	Date of Recovery (MMM/DD/YYYY)	Attending Physician or Hospital	Result

4. Height _____ Weight _____ Has your weight changed in the past year? . . . . . ☐ Yes ☐ No
   If yes, how much? _____ Why? _____

5. Are you now, to the best of your knowledge and belief, in good health and free from all symptoms of illness and disease? . . . . . ☐ Yes ☐ No
   If no, give details below:

Name of Disorder	Date of Onset (MMM/DD/YYYY)	Attending Physician or Hospital	Result

6. Are you now under observation or taking treatment or medication from any physician or alternative health care provider for any disorder, ailment or condition? (Alternative health care provider includes herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.) . . . . . ☐ Yes ☐ No
   If yes, what? _____ Why? _____

7. Who is your regular physician or family doctor? _____ If none, walk-in clinic visited:

   _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

   Approximate Date Last Seen _____ (MMM/DD/YYYY) Reason and Result _____

APPLICANT DECLARATION OF INSURABILITY (CONTINUED)

8. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? ☐ Yes ☐ No

   If yes, give details _____

   _____

9. Have you ever had or been told you had any of the following:
   a) Lung or respiratory disorder (e.g. asthma, bronchitis, tuberculosis, emphysema)? ☐ Yes ☐ No
   b) Heart trouble (e.g. pain in the chest, shortness of breath, high blood pressure, rheumatic fever, murmur, heart attack or stroke)? ☐ Yes ☐ No
   c) Stomach trouble (e.g. ulcer, appendicitis, gall bladder, hernia, or other digestive disorder, colitis)? ☐ Yes ☐ No
   d) Diabetes, kidney disease, sexually transmitted disease, or abnormality of the urine? ☐ Yes ☐ No
   e) Cancer, cyst, tumour, growth or blood disorder? ☐ Yes ☐ No
   f) Epilepsy, paralysis, dizziness or brain disorder? ☐ Yes ☐ No
   g) Neuritis, arthritis, rheumatism, back, spine, bone, joint, or muscle disorder? ☐ Yes ☐ No
   h) Nervous or mental disorders, including depression, anxiety or suicidal thoughts? ☐ Yes ☐ No
   i) AIDS or an AIDS related complex, or had a positive reaction to a test designed to reveal the presence of Human Immunodeficiency Virus (HIV), or any other immunological disorder? ☐ Yes ☐ No
   j) Hepatitis A,B, C or type unknown, or any other disorder of the liver? ☐ Yes ☐ No
   k) Any disease, impairment or deformity not named above? ☐ Yes ☐ No

   If yes to any question in number 9, give details below:

Name of Disorder	Date of Onset	Date of Recovery	Attending Physician or Hospital	Result
	MMM/DD/YYYY	MMM/DD/YYYY		
	MMM/DD/YYYY	MMM/DD/YYYY		

10. Have you ever taken drugs, including marijuana and cocaine for other than medical purposes or been advised to reduce alcohol consumption or received or have been counselled to receive treatment for drug addiction or alcoholism? ☐ Yes ☐ No

    If yes, give details including: frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

    Amount consumed on each occasion _____ Date last used _____ MMM/DD/YYYY

11. Have you ever been refused life insurance or offered insurance modified in any way? ☐ Yes ☐ No

    If yes, date _____ MMM/DD/YYYY Reason _____

12. Tobacco Use: Have you smoked any tobacco products within the past 12 months? (tobacco products include: cigarettes, cigarillos, mini cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana or hashish.) ☐ Yes ☐ No

    If yes, for how long? _____ how many/day? _____

PAYMENT SECTION – PRE-AUTHORIZED DEBIT (PAD) PLAN (pre-authorized debit is the only payment option under this plan)

To ensure accuracy, attach a void cheque in upper right corner.
NOTE: The PAD withdrawals are the 1st of each month.

I have waived my right to receive pre-notification of the amount of the PAD and agreed that I do not require advance notice of the amount of the PADs before the debit is processed.

Name of Financial Institution _____

Address _____ Street _____ City _____ Province _____ Postal Code

Bank Branch (5 digits) _____ Bank Code (3 digits) _____ Account Number _____

Your Payor's PAD agreement may be cancelled provided notice is received 14 days before the next scheduled PAD. If any of the above details are incorrect, please contact us immediately at 1-800-667-8164. If the details are correct, you do not need to do anything further and your Pre-Authorized Debits will be processed and start on the Payment Start Date indicated above.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD that is not authorized or is not consistent with the terms of this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

I hereby authorize Co-operators Life Insurance Company ("Co-operators") to withdraw premium payments from my account for the policy referred to herein and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid for so long as my coverage remains in effect unless revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Bank Depositor Signature _____ Date _____ MMM/DD/YYYY

APPLICANT DECLARATION AND AUTHORIZATION

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I authorize any person or organization who maintains my personal and health records or information to provide Co-operators (or its agents, representatives, and administrators) with my personal and health information for the purpose of underwriting my application for insurance coverage, evaluating my eligibility for any insurance coverage, and adjudicating my insurance claim(s). I authorize Co-operators to release my personal and health information to my physician, the Public Health authorities, and Co-operator's re-insurer(s), when requested. This authorization will remain valid unless I revoke it in writing. A copy of this authorization will be as effective as the original.

I understand that Co-operators (or its agent, representatives, and administrators) may ask me to undergo a medical or paramedical examination(s) to evaluate my eligibility for insurance coverage. If I refuse to undergo such examination(s), this may result in the delay or denial of my application for insurance coverage. I acknowledge that any information I disclose in any paramedical or medical examination or on any medical evidence form(s), questionnaire(s) or other statement(s) given as evidence of insurability will form part of my application for insurance coverage. I certify and declare that I have disclosed true, complete, and accurate information on my application for insurance coverage. I understand and acknowledge that a failure to disclose true, complete and accurate information or a misrepresentation of any material fact(s) may result in Co-operators voiding my insurance coverage.

Signature _____ Date _____ MMM/DD/YYYY