PUHL EMPLOYEE BENEFITS INC.
a benefits management company

Accidental Death & Dismemberment — ENROLMENT FORM & PAD AGREEMENT

Member's First Name	Initial	Member's Last Name	Gender	Date Of Birth (Y/M/D)

Mailing Address	City/Town	Province	Postal Code
		BC	

Phone ( )	COPA Membership ID Number
Email Address	

First & Last Name of Beneficiary *(total amount must equal 100%)*	Date of Birth (mm/dd/yyyy)	Relationship	Amount

A beneficiary designation is revocable unless prohibited by law. If any beneficiary is under the age of majority, it is recommended that you appoint a trustee to receive the payment on behalf of minor children in the event that payment is due prior to attaining the age of majority.

First & Last Name of Trustee:_____ Relationship: _____

Quebec Only: In Quebec only, by law, the designation of your spouse, by marriage or civil union, as a beneficiary is irrevocable, unless otherwise specified. An irrevocable beneficiary designation means that you cannot change your beneficiary without their written approval. ☐ I choose a revocable beneficiary designation for my spouse. Initials _____

Indicate ☑ The Requested Type of Insurance Coverage:

☐ OPTION A - Standard Fixed Wing
☐ OPTION B - Std Fixed Wing & Homebuilt
☐ OPTION C - Std Fixed Wing, Rotary Wing, Flight Instruction
☐ OPTION D - Fixed Wing, Ultra-Light, Glider, Gyroplane & Balloon
☐ OPTION E - Drone Operator
☐ OPTION F - Administration

Indicate ☑ The Requested Amount of Insurance Coverage (The Principal Sum)

☐ $50,000	☐ $75,000	☐ $100,000	☐ $125,000	☐ $150,000	☐ $175,000	☐ $200,000	☐ $225,000
☐ $250,000	☐ $275,000	☐ $300,000	☐ $325,000	☐ $350,000	☐ $375,000	☐ $400,000	☐ $425,000
☐ $450,000	☐ $475,000	☐ $500,000					

PAD AGREEMENT

I hereby authorize the withdrawal of payments under a Pre-Authorized Debit (PAD) Agreement with Group Benefit Underwriters Inc., that is recurring on the first day of each month from the financial institution and account number provided, under which I have signing authority.

I acknowledge Group Benefit Underwriters Inc will charge me a fee if a PAD is declined by the financial institution and will automatically terminate this agreement if a withdrawal is reversed by the financial institution. I agree to a PAD that varies due to changes in a rate, type of coverage, or amount of insurance. I realize a change in PAD account information requires the completion a new agreement, which must be received at least 15 days prior to the next scheduled PAD. This PAD agreement remains in effect until Group Benefit Underwriters Inc. receives written notification from me to cancel this agreement, which must be received at least 15 days prior to the next scheduled PAD.

Indicate ☑ The Requested Method of Premium Payment

example ⑈00 1⑈ ⑆12345⑈ 123⑆ 1234⑈567⑈
TRANSIT INSTITUTION ACCOUNT NUMBER

☐ BANK Transit Number_____ Institution Number_____ Account Number _____

☐ VISA MasterCard Card #:_____ Expiry (M/Y):_____/_____ CVC: _____

Card Holder Name _____

CARD HOLDER SIGNATURE:_____ **Date (Y/M/D)**_____/_____/_____

I hereby authorize the collection, use, and disclosure of health, claims, and other personal information about me by the plan administrator, insurance company, and other service or benefit providers and their respective agents and service providers, and the disclosure of personal information by any person or organization having information about me, including medical professionals, institutions, employers, insurance companies, and other service or benefit providers, for underwriting, claims adjudication, and other administrative activities under this plan.

I hereby acknowledge that authorization is a requirement under this plan, and a copy of this authorization shall be as valid as the original. I hereby declare that all personal and payment information provided in this Enrollment Form & PAD Agreement is accurate and complete.

MEMBER SIGNATURE_____ **DATE (Y/M/D)**_____/_____/_____

Plan Administration Services Are Provided By: GROUP BENEFIT UNDERWRITERS

Send This Form To:
Copa Care Travel Insurance
#209-2577 Bridlecrest Way SW
Calgary Alberta T2Y 5J4
arlene.marko@puhlemployeebenefits.com
1-888-508-0077