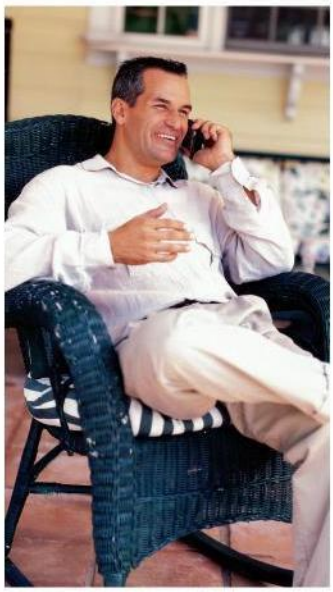

Professional Pilot Insurance Plan

Loss of Licence Application

www.ppip.ca
ppip@rbiadvisory.com

Application Form

International Form for Loss of Commercial Flying Licence Insurance

PART 1 - INSTRUCTIONS AND RESPONSIBILITIES:

1. All sections of this application form **MUST** be completed in full.

2. The Insurer relies on the application form containing all material information about you to be true and complete. Material information is **anything** that may influence the Insurers decision to issue a policy or not or to decide on what terms a policy will be offered to you. If you are unsure if something is material, you **must** disclose it.

3. If there is any change in the information declared after the date you sign this application form and before any policy offered by the Insurer commences, you must advise the Insurer immediately. The Insurer may alter the terms quoted to you in such circumstances.

4. If you do not make a true and complete disclosure of material information, the Insurer may at their election cancel your policy or modify the terms on which it was issued. It will also prejudice your ability to claim under the policy.

DATA PROTECTION

Catlin includes Catlin Underwriting Agencies Limited and Catlin Insurance Company (UK) Ltd. ("the Insurer")

The information provided on this form, together with medical and any other information obtained from you or from other parties about you in connection with this policy, will be used by the Insurer for the purposes of determining your application, the operation of insurance (which includes the process of underwriting, administration, claims management, rehabilitation and customer concerns handling) and fraud protection and detection.

Information may be transferred overseas for these purposes.

Information may be shared by the Insurer for these purposes with group companies and third party insurers, reinsurers, insurance intermediaries and service providers. Such parties may become data controllers in respect of your personal data.

By completing and submitting this form, you consent to the processing of any personal data about you, including sensitive personal data, the transfer of such personal data about you overseas for these purposes as set out in this notice by the Insurer and such third parties and any other data controllers to which the personal data are transferred or disclosed for these purposes.

Your personal data will only be available to those who need to see it. For example, sensitive data, such as medical records will be used for the purposes of underwriting or claim management and rehabilitation only.

You are entitled to a copy of all your personal data upon receipt of a written request to the following address:
The Compliance Officer, Catlin Insurance Company (UK) Ltd., 20 Gracechurch Street, London, EC3V 0BG.

Once completed, forward your application to: Professional Pilot Insurance Plan, P.O. Box 89 Station Main, Okotoks Alberta T1S 1A4
Email: ppip@rbiadvisory.com Fax 403 939 0232 Questions? Call 1 888 724 1444

PART 2 - PERSONAL INFORMATION:

1. Surname:

2. First name(s):

3. Rank:

4. Date of birth: (dd/mmm/yyy)

5. Main employer:

6. Date insurance to commence: (dd/mmm/yyy)

7. Annual taxable earned income from your main employer:

8. Any other earned income from flying:

9. During a period of disability, does your employer provide contractual sick pay?
If **YES**, how much and for how long: Yes ☐ No ☐

10. During a period of disability are you entitled to benefit from any other loss of license, disability or accident insurance policy which pays a temporary benefit?
If **YES**, how much and for how long: Yes ☐ No ☐

11. During a period of disability will you receive any other regular income?
If **YES**, how much and for how long: Yes ☐ No ☐

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Email: ppip@rbiadvisory.com Fax 403 939 0232 Questions? Call 1 888 724 1444

12. Are you entitled to benefit from any other loss of license, disability or accident insurance policy which pays a lump sum benefit only?
If **YES,** please give name of insurer(s), policy number(s) and benefit payable. Yes ☐ No ☐

13. Type of aircraft flown: (please tick all which apply):

Fixed Wing	
Rotor Wing (On Shore)	
Rotor Wing (Off Shore)	

14. All current licences held: (Please specify type, number, country of issue and whether any limitations apply or have applied previously)

Type	**Number**	**Country of Issue**	**Limitations (yes or no)**

Please give details of any licence limitations in **PART 6 - SUPPLEMENTARY INFORMATION**

PART 3 - BASIS OF COVER:

15. Sum to be insured:

16. Please state if this Application is: (Please tick which applies)

a) Your first application to the Insurer, ☐

Or

b) An additional amount to an existing insurance ☐
(If b) state existing Policy No. and amount insured and insurer)

PART 4 - MEDICAL INFORMATION:

17. Do you hold a current medical certificate? Yes ☐ No ☐

18. What is your height: (cm) ☐ What is your current weight: (kg) ☐

19. Has there been any significant change in weight in the last year? (± 6.5kg) Yes ☐ No ☐
If **YES**, please give details:

20. Date of last aircrew medical examination: (dd/mmm/yyy) ☐

Were you advised of any abnormality, referred for additional tests, specialist examination or asked to follow any treatment or diet plan? Yes ☐ No ☐
If **YES**, please give details:

21. Date of last electrocardiograph taken as required by the Licensing Authority: (dd/mmm/yyy) ☐

Were you advised of any abnormality, referred for additional tests, specialist examination or asked to follow any treatment plan? Yes ☐ No ☐
If **YES**, please give details:

22. Have you been investigated, diagnosed or treated for any of the following:

a) Cancer, leukemia, Hodgkin's disease, lymphoma, or any malignant condition? Yes ☐ No ☐

b) A mole or freckle that has bled, caused pain or changed in appearance or any lump or growth? Yes ☐ No ☐

c) Heart disease (including heart attack, angina, valve defect, heart defects from birth or heart surgery)? Yes ☐ No ☐

d) Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol? Yes ☐ No ☐

e) Any other chest complaint? Yes ☐ No ☐

f) Disease or disorder of the arteries (including disease in the legs or of the aorta)? Yes ☐ No ☐

g) Stroke, Transient Ischemic Attack [TIA], brain hemorrhage or brain injury? Yes ☐ No ☐

Failure to disclose relevant information may result in the non-payment of a claim and all coverage under the policy being cancelled.

Once completed, forward your application to: Professional Pilot Insurance Plan, P.O. Box 89 Station Main, Okotoks Alberta T1S 1A4
Email: ppip@rbiadvisory.com Fax 403 939 0232 Questions? Call 1 888 724 1444

h)	Asthma, bronchitis, lung or any other respiratory disorder?	Yes ☐	No ☐
i)	Multiple Sclerosis, optic or retrobulbar neuritis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia, bell's palsy or cerebral palsy?	Yes ☐	No ☐
j)	Any other disorder of the central nervous system not already mentioned?	Yes ☐	No ☐
k)	Numbness, loss of feeling or tingling of the limbs or face, loss of balance or coordination?	Yes ☐	No ☐
l)	Seizures, fits, fainting, unexplained loss of consciousness or blackouts?	Yes ☐	No ☐
m)	Mental illness or psychological problems that have required any kind of medical attention, time off work, hospital treatment or referral to a psychiatrist?	Yes ☐	No ☐
n)	Depression, anxiety, stress, insomnia, fatigue (including chronic fatigue syndrome [CFS] / myalgic encephalopathy [ME]) or nervous breakdown?	Yes ☐	No ☐
o)	Any disorder of the eyes or ears including blurred or double vision, or impaired hearing?	Yes ☐	No ☐
p)	Gout, arthritis, back pain, sciatica, neck, knee or wrist pain?	Yes ☐	No ☐
q)	Any other disorder of the joints, bones or muscles (including repetitive strain injury)?	Yes ☐	No ☐
r)	Diabetes, abnormal glucose tolerance or sugar in the urine?	Yes ☐	No ☐
s)	Disorder of the kidneys, bladder, or the genitourinary system (including blood or protein in the urine and urinary tract infections)?	Yes ☐	No ☐
t)	Any disorder of the digestive system, gall bladder, liver, stomach, spleen, pancreas, bowel (including ulcers, hepatitis, colitis or Crohn's disease or any other form of bowel disease)?	Yes ☐	No ☐
u)	Any blood disorder or anemia?	Yes ☐	No ☐
v)	Thyroid or other glandular disorder?	Yes ☐	No ☐
w)	Any gynecological, menstrual or breast problems (e.g. breast lumps)? (female applicants only)	Yes ☐	No ☐
x)	Any prostate problems or problems relating to the breast tissue? (male applicants only)	Yes ☐	No ☐
y)	Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test?	Yes ☐	No ☐
z)	Any disease which was transmitted sexually?	Yes ☐	No ☐
aa)	Are you currently taking any form of medication, prescribed or otherwise or following any special diet or treatment or have you taken any form of medication for longer than 21 days?	Yes ☐	No ☐
bb)	Do you have any further disclosures to make with regard to any medical investigation, test or consultation, advice, counseling, operation, medication or treatment that you have had or been advised to have or are currently having, but have not already mentioned?	Yes ☐	No ☐

If you have answered **YES** to any of the above, please provide further information regarding the condition, including treatment (whether proposed or received), medication (whether proposed or received) and prognosis in process.

PART 6 – SUPPLEMENTARY INFORMATION

23. During the last 5 years have you been off work, unable to carry out your normal duties due to sickness or injury for more than 21 days at any one time, other than previously stated? Yes ☐ No ☐
If **YES,** please give details:

24. Are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment? Yes ☐ No ☐
If **YES,** please give details:

25. Have you ever been advised by your doctor or another medical practitioner to drink less alcohol? Yes ☐ No ☐
If **YES,** please give details:

26. Have you used any form of tobacco or nicotine products in the last 12 months? Yes ☐ No ☐
If **YES,** please give details of quantity per week:

27. Have your parents, brothers or sisters, before the age of 65, died or suffered from, or had any investigations for heart disease, stroke, polycystic kidney disease, cancer or tumour or diabetes, Multiple Sclerosis or Polyposis of the colon? Yes ☐ No ☐
If **YES**, please give details including age when diagnosed:

28. Have you ever had an application for loss of licence, life, critical illness or income protection insurance postponed, declined, accepted with an increased premium or on special terms? Yes ☐ No ☐
If **YES**, please give details:

29. The Insurer may require additional medical information. If you have completed any section declaring medical history, please complete the following:

Usual Doctor or General Practitioner's name and contact address:

Consultant's name and contact address:

PART 5 - DECLARATION:

I hereby declare:

- that I have read the answers to the questions in this application form and, to the best of my knowledge and belief, the answers, whether in my own handwriting or not, are true and complete.
- that I have not withheld any material information which might influence the decision of the Insurer with regard to this proposal.

I agree that this proposal and declaration shall be the basis of the Contract between me and the Insurer if a policy is issued. I also consent to any information the Insurer may have about me being processed by them for the purposes of providing insurance and claims handling which may necessitate them providing such information to third parties.

Signed Dated

(dd/mm/yyyy)

The Insurer reserves the right to impose special conditions or refuse to accept an application for insurance.

PART 6 – SUPPLEMENTARY INFORMATION

Which question does this information relate to?

Date of occurrence (if more than one episode, please give all dates):

Diagnosis (suspected or confirmed):

Details of any treatment/medication received:

Periods off work (if no time off work, the duration of the problem):

If you had time off work, were the Licensing Authorities advised of your condition? **YES/NO** (please delete as applicable). If **YES,** please give details of all formal groundings and any license limitations imposed:

Is any further problem or treatment anticipated? **YES/NO** (please delete as applicable). If **YES** please give further details:

If no further problem or treatment anticipated, has a full recovery been made? **YES/NO** (please delete as applicable). If **NO** please give further details:

Which question does this information relate to?

Date of occurrence (if more than one episode, please give all dates):

Diagnosis (suspected or confirmed):

Details of any treatment/medication received:

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Is any further problem or treatment anticipated? **YES/NO** (please delete as applicable). If **YES** please give further details:

If no further problem or treatment anticipated, has a full recovery been made? **YES/NO** (please delete as applicable). If **NO** please give further details:

FREE TEXT AREA BELOW FOR ANY ADDITIONAL INFORMATION TO BE DECLARED:

Professional Pilot
Insurance Plan

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Please print, complete and sign

MEMBER INFORMATION

Last Name	Given Name	Initials	Employer (optional)

STEP 1 - PROVIDE DETAILS FOR MONTHLY PRE-AUTHORIZED DEBITS

ATTACH A PERSONALIZED 'VOID' CHEQUE OR COMPLETE THE INFORMATION BELOW

ACCOUNT DETAILS

Name(s) of Account Holder(s) as shown on Financial Institution records

Street Address of Account Holder(s)	City	Prov.	Postal Code

Name of Financial Institution

Street Address of Branch	City	Prov.	Postal Code

Financial Institution Number	Transit Number	Account Number

WITHDRAWAL ARRANGEMENT

☐ Fixed ☑ Variable

STEP 2 - REVIEW AND PROVIDE AUTHORIZATION

RECOURSE

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 debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

AUTHORIZATION FORM MUST BE SIGNED IN INK

I/we, as the Account Holder(s), authorize Professional Pilot Insurance Plan (PPIP) and the financial institution named above or as indicated on the attached 'VOID' cheque, to withdraw variable monthly payments from my/our account, at the branch indicated, for the purpose of collecting premiums and any applicable sales tax and service charges for insurance under this policy.

The PAD amount will be debited from the account indicated above on the 1st day of each month or the next business day. I/we agree to notify PPIP in writing, if there is any change to the banking information set out above.

I/we waive the right to receive pre-notification of the amount to be debited each month and the date of such debit. I/we agree, PPIP will provide written notice of the amount of the PAD at least three (3) calendar days before the first PAD is debited and before any increase to the PAD amount is debited, except when the increase is due to a change in sales taxes, service charges, or the increase to the PAD amount is a result of my/our request.

I/we may cancel this PAD Agreement at any time, subject to providing notice to PPIP at the address provided below. This notification must be received at least ten (10) business days before the next debit is scheduled. I/we may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/we understand that cancellation of this PAD Agreement will not have any effect on the insurance provided under this policy, provided that payment is received when due and is made in accordance with the terms of this policy.

This PAD Agreement only applies to the method of payment. I/we understand that completing this PAD Agreement does not mean that the application for insurance has been approved.

X		X	
Pilot Member Signature (must always sign)	Date (dd-mmm-yyyy)	**Signature of all other Account Holder(s)** (if a required signatory to this account)	Date (dd-mmm-yyyy)

PLEASE SEND YOUR COMPLETED FORM TO:

Professional Pilot Insurance Plan
Box 89, Station Main, Okotoks, AB T1S 1A4

Contact us toll-free at **1-888-724-1444**
Monday to Friday from 08:30 to 16:30 (Mountain Time)
or email ppip@rbiadvisory.com fax 403 938 0232