SMOKER/NON-SMOKER DECLARATION FORM

Supplementary Declaration re Smoking Habits Forming a part of an Application for Insurance	
Name of Employee:	Gender: ❒ Female ❒ Male
OPC Member #:	School Board:
Name of Spouse (if applicable):	

Tick off the appropriate Box	Employee	Spouse (if applicable)
1. I certify as a true fact that I have used tobacco products during the 12 month period immediately preceding the date written below beside my signature.	❒	❒
2. I certify as a true fact that I have not used tobacco products during the 12 month period immediately preceding the date written below beside my signature	❒	❒

I understand and agree that the premiums charged for my (or my spouse's) insurance coverage are based in part on the statements given by me (or my spouse) on this form. I certify that the statements are accurate, true and complete in all respects. In the event that any such statement is inaccurate, untrue or incomplete in any respect, I understand and agree that all insurance coverage is voidable by the insurer. I further agree that in such event the insurer's liability to paying to the designated beneficiary/beneficiaries is the amount of any premium I paid for insurance coverage.

Employee Signature: _____ Date _____

Spouse Signature: _____ Date _____
(if applicable)

Please return the completed original form to:

OPC Benefits Centre
20 Queen St. W., Suite 2700
PO Box 7
Toronto, Ontario
M5H 3R3