

ENROLMENT FORM GROUP INSURANCE

New employee

Reinstatement



1 - ADMINISTRATIVE INFORMATION (to be completed by the employer)

| | | | | | | |
|----------------------------|--------|--|--------------------------|----------------------------|-----------|--------|
| EMPLOYER NAME | | POLICY NO. | DIVISION | | CLASS NO. | |
| CERTIFICATE NO. (If known) | | OCCUPATION | | | | |
| HOURS WORKED PER WEEK | | DATE EMPLOYED ON A FULL-TIME BASIS | | INSURANCE ELIGIBILITY DATE | | |
| Details of income | Amount | Indicate if salary amount is hourly, weekly, bi-weekly or annual | | | | |
| Hourly wage | | Hourly | | | | |
| Salary | | Weekly | Bi-weekly | Monthly | Annually | Other: |
| Bonus | | Weekly | Bi-weekly | Monthly | Annually | Other: |
| Commission | | Weekly | Bi-weekly | Monthly | Annually | Other: |
| Employer's signature | | | Date signed (MM/DD/YYYY) | | | |

2 - EMPLOYEE INFORMATION (To be completed by the employee)

| | | | | | |
|-----------------------------------|-----------------------|---------------------|-------------------------|--|-------------|
| LAST NAME | | FIRST NAME | | DATE OF BIRTH | |
| ADDRESS : Number, street, apt. | | CITY | | PROVINCE | POSTAL CODE |
| Male Female | Language Preference : | | | | |
| EMAIL ADDRESS | | PHONE NUMBER | | DO YOU HAVE A PROVINCIAL HEALTH CARD? | |
| Marital Status | Single Widow(er) | Married Divorced | Separated Common Law | If common-law spouse, cohabitation start date (MM/DD/YYYY) | |

3 - SUPP. HEALTH AND/OR DENTAL CARE COVERAGE

Individual (if single go to question 5)

Family Couple Single parent
(For family, couple or single parent coverage answer question 3A)

Waived (If waived, go to question 3A, 3B, 3C)

3A - DEPENDENT LIFE INSURANCE

With some insurers, dependant life insurance is mandatory for members who have a spouse (or common-law spouse) and /or children. Please check with your plan administrator for further details.

I would like my dependants to receive life insurance coverage (if possible).

3B - SUPPLEMENTARY HEALTH AND/OR DENTAL CARE COVERAGE WAIVER

Supplementary health (Prescription drugs, Paramedical services):

I waive this coverage for myself and my dependants
I waive this coverage only for my dependants

Dental Care

I waive this coverage for myself and my dependants
I waive this coverage only for my dependants

Excerpt from RAMQ's website

Persons who fulfill the eligibility requirements for a private plan must join that plan... If the employer offers a private plan, the employees are required to join that plan, unless they can prove that they are covered by another private plan (another group insurance or employee benefit plan).

Read the full text

3C - OTHER COVERAGE AND COORDINATION OF BENEFITS

Are you or your dependants covered by another plan? Yes or No

If so, please provide the following information:

Policy Holder: _____ Insurer: _____

Effective date of coverage (other plan): _____ Policy number: _____

Certificate/Identification number: _____

4 - DEPENDANT INFORMATION

Please list any dependants. If more space is required, attach a separate sheet.

| First name | Last name | Relationship | Date of birth (MM/DD/YYYY) | Gender (M/F) | Disabled child | Full time student (Age 21-26)* | Dependant has a provincial health card. |
|------------|-----------|--------------|----------------------------|--------------|----------------|--------------------------------|---|
| | | | | | Yes | Yes | Yes |
| | | | | | Yes | Yes | Yes |
| | | | | | Yes | Yes | Yes |
| | | | | | Yes | Yes | Yes |

* May vary by insurance carrier. Please refer to your insurance contract.

5 - BENEFICIARY DESIGNATION

| Last name | First name | Date of birth | | | Relationship to Employee | % | You MUST select one of the following | |
|-----------|------------|---------------|----|----|--------------------------|---|---|-------------|
| | | YYYY | MM | DD | | | Revocable | Irrevocable |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

REVOCABLE: Means that the beneficiary designation may be changed without the beneficiary's consent.

IRREVOCABLE: Means that the beneficiary designation **CANNOT** be changed without the beneficiary's consent.

The **IRREVOCABLE** designation of a minor **CANNOT** be changed before he reaches the age of majority.

CONTINGENT BENEFICIARY

Not applicable in Quebec, the provisions of the Civil Code shall apply.

For other provinces: Complete this section **ONLY** if you have designated a minor beneficiary.

| | | | | | | | |
|----------------------------------|--|--|------|---------------------------------|--|----------|-------------|
| FULL NAME OF THE TRUSTEE | | | | RELATIONSHIP TO THE BENEFICIARY | | | |
| ADDRESS: Number, street, apt. | | | CITY | | | PROVINCE | POSTAL CODE |

6 - AUTHORIZATION

I authorize my employer, the policyholder, the insurers, and their respective representatives to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any, under this Program, within the limits of the law regarding the protection of personal information.

I hereby accept the conditions of this policy and I authorize the necessary contributions to be made through salary deductions.

I agree to the use of a Participant's number under this plan and as my identifier for my Employer's Group Insurance Program.

In case of death, I expressly authorize the policyholder, the employer, the beneficiary, heir or liquidator of my estate to provide the insurers, when required, with all the information and authorizations pertaining to the adjudication of the claim and the obtaining of evidence.

This consent is valid for the purpose of this policy, or any modification, extension or reinstatement of thereof.

A photocopy of this consent is as valid as the original if it used for information sharing purposes.

| | |
|--------------------|-------------------|
| EMPLOYEE SIGNATURE | DATE (MM/DD/YYYY) |
|--------------------|-------------------|