

# EMPLOYEE APPLICATION FOR GROUP INSURANCE

TO BE COMPLETED BY EMPLOYER		
Employee's Occupation/Position	Classification	Date of Hire (dd/mm/yy)
	[ ] A [ ] B	/ /

## 1 Provide personal information below

Name of Applicant (Last/First/Initial)	Birth Date (dd/mm/yy)	Sex	Height (ft/in)	Weight (lbs.)
	/ /	[ ] M [ ] F		
Mailing Address (Street/City/Province/Postal Code)	Home Telephone Number	Business Telephone Number		
	( )	( )		
Name of Employer	Social Insurance Number	Earnings	Usual Work Week	
	/ /	\$ per	hrs	
Name of Beneficiary to Receive Benefits Payable on Your Death (Full Legal Name)	Designation Revocable?	Beneficiary's Relationship to You (e.g., Spouse)		
	[ ] Yes [ ] No			
If Applying for Optional Spousal Life Insurance, Give Spouse's Name (Last/First/Initial)	Birth Date (dd/mm/yy)	Sex	Height (ft/in)	Weight (lbs.)
	/ /	[ ] M [ ] F		

## 2 Choose the coverage you require

	Check One Box On Each Line			
<b>CORE PLAN</b>				
<i>Basic Life, AD&amp;D Coverage</i>	[ ] Class A - \$50,000		[ ] Class B - \$25,000	
<i>Extended Health Benefit Coverage</i>	[ ] Single	[ ] Family	or [ ] Waive this benefit	
Dental Benefits (if applicable)	[ ] Single	[ ] Family	or [ ] Waive this benefit	
Long Term Disability (if applicable)	[ ] Class A - \$1,500		[ ] Class B - \$1,000	
<i>Check Additional Amount Desired:</i>	[ ] \$0	[ ] \$500	[ ] \$1,000	[ ] \$1,500
Optional Life Insurance for Applicant	[ ] \$50,000	[ ] \$100,000	[ ] \$ _____	
Optional Life Insurance for Spouse	[ ] \$50,000	[ ] \$100,000	[ ] \$ _____	

## 3 Answer "yes" or "no" to the following questions. Information about your spouse is required if you are applying for optional life insurance for your spouse

	Applicant	Spouse
1. Have you ever had or been treated for heart trouble, high blood pressure, ulcerative colitis, kidney disorder, diabetes, any mental or nervous disorder, alcoholism, lung disorder, cancer, tumors, or joint/limb disorder (including neck/back)?		
2. Have you ever had or been told you had Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or had a positive test related to the HIV virus or AIDS?		
3. Have you consulted a physician or received treatment at any time in the last five (5) years for any disease, ailment, injury or mental condition not included above?		
4. Have you any condition for which hospitalization or surgery has been advised, or is contemplated within the next 12 months?		
5. Have you used tobacco products within the past 12 months?		
6. Have you ever been refused life or disability insurance or been offered insurance which has been modified in any way? (If yes, specify name of insurer and reason)		

## 4 If "yes" to any of the preceding questions, please provide detailed information below

Question #	Details of Diagnosis, Duration and Result	Date Treated	Name & Address of Physician/Hospital
[ ] Applicant [ ] Spouse			
[ ] Applicant [ ] Spouse			
[ ] Applicant [ ] Spouse			
[ ] Applicant [ ] Spouse			

I consent to the collection, use, and exchange of my personal information, including my Social Insurance Number, by my employer, the administrators of my retirement, savings, and other employee benefits programs, the agents retained by my employer or the administrator, an insurance company, and/or any other person who requires information for the purpose of retirement, savings, or other employee benefits plan administration. I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my minor children that they require for the purposes of determining my benefit entitlements, and for record-keeping, file identification, reporting, procurement of health information, claims resolution, program management, and other services provided to me and my employer from time to time. I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time. (NOTE: In the province of Quebec, in the absence of an irrevocable/revocable designation, the legal spouse is deemed to be irrevocable and other beneficiaries are deemed to be revocable. An irrevocable designation cannot be changed without the beneficiary's written consent.) I hereby apply for group insurance benefits under my employer's plan and authorize any required deductions.

Applicant's signature

Date signed

Spouse's signature

Date signed