APPLICATION FOR GROUP COVERAGE

Employer Section

This section is to be completed by the plan administrator

Plan number: _____ Division number: _____ Benefit class: _____

Employer: _____ SIN: _____

Date of full-time employment: Month: _____ Day: _____ Year: _____

Occupation: _____ Earnings: _____ per ○ year ○ month ○ week ○ hour

Employee province of residence: _____ Employee province of employment: _____

Employee Information

This section is to be completed by the employee

Please print clearly, in INK

Employee: _____
last name first name middle initial

Gender: ○ male ○ female Date of birth: Month _____ Day _____ Year _____

Employee mailing address:
Street address: _____

City: _____ Province: _____ Postal Code: _____

Do you have a spouse/common law spouse? ○ Yes ○ No

Do you have other dependents, which includes children/students/disabled persons? ○ Yes ○ No

How many dependents in total, including spouse/common law spouse? _____

Refusal of Benefits

This section is to be completed by the employee.

Health, dental and/or vision coverage may only be removed if you have duplicate group benefits through your spouse's employer.

In addition, vision coverage may only be removed it is separate from healthcare in your group benefits plan.

I understand the plan of group benefits offered to me, but **I decline** to participate in:

Healthcare for	○ myself and my dependents	○ my dependents only
Dentalcare for	○ myself and my dependents	○ my dependents only
Visioncare for	○ myself and my dependents	○ my dependents only

Note: Coverage can only be refused if you and/or your dependents are covered by duplicate group benefits through your spouse's employer.

Spousal insurer's name: _____ Plan number: _____

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you may be required to provide acceptable proof of your insurability to be covered. If you are approved, dental benefits, if applicable, may be limited.

Please see your plan administrator for details.

Dependent Information

This section is to be completed by the employee.

Complete this section if you have not refused dependent coverage. If there are more than 4 dependents, please attach a separate list. Please print clearly, in INK.

Spouse/Common Law Spouse Information

_____
last name first name middle initial

Date of birth (month/day/year)
_____

Gender
○ Male ○ Female

What group benefits coverage does your spouse/common law spouse have through an employer?

	Single	Family	Waived	None
HEALTHCARE	○	○	○	○

	Single	Family	Waived	None
DENTALCARE	○	○	○	○
VISIONCARE	○	○	○	○

To be completed by the plan administrator

Plan number: _____ **Employee name:** _____

Dependent Information			**Date of birth** month/day/year	**Gender**		**Full time student**		**Disabled dependent**	
last name	first name	middle initial		Male ○	Female ○	Yes ○	No ○	Yes ○	No ○
last name	first name	middle initial		Male ○	Female ○	Yes ○	No ○	Yes ○	No ○
last name	first name	middle initial		Male ○	Female ○	Yes ○	No ○	Yes ○	No ○
last name	first name	middle initial		Male ○	Female ○	Yes ○	No ○	Yes ○	No ○

Over Age Student Information (for full time students over age 21)

Name of Over Age Student	**School Attended (University or College)**	**Enrolled From (DD/MM/YY)**	**Enrolled To (DD/MM/YY)**
_____	_____	_____	_____
_____	_____	_____	_____

Beneficiary Designation

This section is to be completed by the employee.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

The original copy of this form will be required for a life claim.

Please print clearly, in INK.

Beneficiary's Name(s)			Percent allocated	Relationship to Employee
last name	first name	middle initial		
last name	first name	middle initial		
last name	first name	middle initial		

You must make your beneficiary designation revocable or irrevocable by checking one of the circles below. You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary.

Note: Where Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable" below.

I hereby make the above beneficiary designation: ○ **Revocable** ○ **Irrevocable**

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

I designate the person(s) names above under Beneficiary Designation as my beneficiary. I certify that the information in this form is true and complete, to the best of my knowledge. If applying for benefits for my dependents, I am authorized to release information concerning my spouse/common law spouse and my dependents for the purpose of determining their eligibility for benefits. If my social insurance number is used as my certificate number, I authorize use for the identification and administration of my group benefits.

_____ _____

Employee Signature Date

Once completed, submit to:
Canadian Benefits Administrators
1160, 10655 Southport Road SW
Calgary AB T2W 4Y1