



**EMPLOYEE  
APPLICATION FOR GROUP  
COVERAGE**

**EMPLOYER SECTION:** This section is to be completed by the Employer's Plan Administrator. PLEASE PRINT CLEARLY IN INK.

Employer: \_\_\_\_\_

Association Name: \_\_\_\_\_ Employee #: \_\_\_\_\_

Date of full-time employment: (dd/mm/yyyy): \_\_\_\_\_ Date Eligible: (dd/mm/yyyy) \_\_\_\_\_

Occupation: \_\_\_\_\_

Earnings: \_\_\_\_\_ per  year  month  week  hour No. of hours per week: \_\_\_\_\_

Employee: Residence Province: \_\_\_\_\_ Employment Province: \_\_\_\_\_

**EMPLOYEE SECTION:** This section is to be completed by the Employee. PLEASE PRINT CLEARLY IN INK.

Employee Name: \_\_\_\_\_  
last name first name middle initial

Gender:  male  female Date of birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

SIN #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(street no.) street name (city) (province) postal code

Do you have a spouse/common law spouse?  Yes  No other dependents - children/students/disabled persons?  Yes  No

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

**REFUSAL OF BENEFITS:** Health, Dental and/or Vision coverage may only be removed if you have DUPLICATE group benefits through your spouse's employer.

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

Spousal insurer's name: \_\_\_\_\_ Policy No.: \_\_\_\_\_

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 restricted.

Please see your plan administrator for details.

**DEPENDENT INFORMATION:** Complete this section if you have NOT REFUSED dependent coverage. PLEASE PRINT CLEARLY IN INK. If there is not enough room to list all your dependents, please attach a separate list.

**Spouse/Common Law Spouse Information**

\_\_\_\_\_

last name first name middle initial

Date of birth (m/d/y) \_\_\_\_\_

Gender  Male  Female

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

	Single	Family	Waived	None
HEALTHCARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DENTALCARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FOR COORDINATION OF BENEFITS:**

Spousal Insurance Company Name: \_\_\_\_\_

Policy No.: \_\_\_\_\_

To be completed by the Plan Administrator.

Policy No.: \_\_\_\_\_ Div. No.: \_\_\_\_\_ Employee Name: \_\_\_\_\_

Dependent Information (Continued):			Date of birth month/day/year	Gender		Full time student Over 21		Disabled dependent	
last name	first name	middle initial	_____	Male	Female	Yes	No	Yes	No
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 to designate a beneficiary for your life benefits. The original copy of this form will be required for a life claim. PLEASE PRINT CLEARLY IN INK.

Beneficiary's Name(s) *	DOB (YYYY/MM/DD)	Percent allocated	Relationship to Employee
last name first name middle initial	_____	_____	_____
last name first name middle initial	_____	_____	_____
last name first name middle initial	_____	_____	_____

\* Trustee Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(Required if beneficiary is a minor under age 18)

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.

**Authorizations & Declarations:**

I certify that the information in this form is true and complete, to the best of my knowledge. If applying for benefits for my spouse/common law spouse and/or 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. I authorize Unigroup Inc. to make any and all inquiries, or to exchange information, relating to group benefits claims and administration on behalf of myself and my dependents.

For Quebec applicants: I request that this form be in English. Je demande que ce formulaire me soit remis en anglais.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date