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**EMPLOYEE
APPLICATION FOR GROUP
COVERAGE**

EMPLOYER SECTION: This section is to be completed by the Plan Administrator.

Employer: _____
Policy No.: _____ Division No.: _____ Benefit Class: _____ ID #: _____
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	What group benefits coverage does your spouse/common law Spouse have through an employer?			
_____	Single	Family	Waived	None
last name first name middle initial				
Date of birth (m/d/y) _____	HEALTHCARE <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	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		Disabled dependent	
_____	_____	_____	_____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
last name	first name	middle initial							
_____	_____	_____	_____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
last name	first name	middle initial							
_____	_____	_____	_____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
last name	first name	middle initial							
_____	_____	_____	_____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
last name	first name	middle initial							

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 AND INITIAL ANY SCRATCH OUTS OR WHITE-OUTS.

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 boxes 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 box 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 designate the person(s) named 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 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 Unistar Special Risks 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