

1. TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT) AND MAIL TO MARY GALWAY AT THE ABOVE ADDRESS OR FAX TO 1.888.584.6789

Member/Employee _____ **SIN** _____
First Name(s) Last Name

Municipality _____ **Division** _____

Date of Birth ____/____/____ **Gender** Male, Female
DAY MON YR

	Birth Date			Sex	Children Status if over age 21 S = Student D = Disabled
	Day	Mon	Yr	M/F	
Spouse					
Dependent Children					

Member/Employee Address

Street _____

City or Town _____

Province _____

Postal Code _____

Telephone # (____) _____

2. BENEFITS

A. Dental : Single Family

B. Health : Single Family

C. **Optional Benefits** (Please consult your Employer or Plan Administrator for information on Optional Benefits)

3. WAIVER OF BENEFITS

I **DO NOT** require Health Dental as I am currently covered through my spouse's plan, or an alternative plan as indicated below. I understand that to enrol at a later date I may have to provide evidence of insurability.

Employer _____ Insurance Company _____

X Signature of Insured _____ **Date** ____/____/____
DAY MON YR

4. CO-ORDINATION OF BENEFITS

With Co ordination of Benefits, you may be able to obtain reimbursement up to 100% of your eligible expenses. Please indicate coverage level (single/couple/family), your spouse/dependent has with another insurance provider

Name of Family Member: _____ Insurance Company: _____

Health : Single Couple Family
 Dental : Single Couple Family

Policy Number: _____

5. BENEFICIARY DESIGNATION

I name the following Beneficiary and reserve the right to change or cancel this at a later date

First Name(s) Last Name Relationship Date of Birth ____/____/____
DAY MON YR

If Beneficiary is under 18, please name Trustee. _____
First Name(s) Last Name

In the event that my Beneficiary predeceases me, the following Contingent Beneficiary shall be entitled to the benefits:

Name: _____ Date of Birth ____/____/____
DAY MON YR

X Signature of Insured _____ **Date** ____/____/____
DAY MON YR

6. I hereby apply for benefits under my Employer's plan and authorize any required payroll deductions. I consent to the use of my Social Insurance Number by any insurer or administrator for record keeping, file identification, and/or reporting purposes.

X Signature of Insured _____ **Date** ____/____/____
DAY MON YR

Do you wish to apply for OPTIONAL (employee-paid) life insurance? YES NO If Yes: For self For spouse

Do you wish to apply for OPTIONAL (employee-paid) Accidental Death and Dismemberment insurance? YES NO If Yes: For self For spouse

IF YOU HAVE INDICATED "YES" YOU WILL BE CONTACTED BY THE PLAN ADMINISTRATOR WITH FURTHER INFORMATION

7. TO BE COMPLETED BY EMPLOYER (PLEASE PRINT)

Full-time Permanent Part-time Permanent Seasonal Elected Members Early Retiree Retiree Over 65

Annual Earnings: \$ _____ Earnings per: Hour \$ _____ Week \$ _____ Month \$ _____

Date of Hire ____/____/____ **Effective Date of Coverage** ____/____/____
DAY MON YR DAY MON YR