GROUP BENEFITS ENROLLMENT FORM

SECTION #1: GROUP PLAN INFORMATION

EMPLOYER NAME	DIVISION NUMBER	CLASS	IDENTIFICATION NUMBER

SECTION #2: PLAN MEMBER INFORMATION

EMPLOYEE NAME

First Name **Middle Name** **Last Name**

GENDER	DATE OF BIRTH	DATE OF HIRE	WAIVE WAITING PERIOD
☐ MALE ☐ FEMALE ☐ OTHER	*(MM/YY/DD)*	*(MM/YY/DD)*	☐ YES | ☐ NO ***A letter requesting to waive the waiting period must accompany this form***
ANNUAL EARNINGS **$_____ per year**	**NO. HOURS PER WEEK** **_____ per week**	**PREFERRED LANGUAGE** ☐ ENGLISH ☐ FRENCH	**MARITAL STATUS** ☐ SINGLE ☐ MARRIED ☐ COMMON-LAW

MAILING ADDRESS

Street **City** **Province** **Postal Code**

SECTION #3: EMPLOYEE DECLARATION OF SMOKING HABITS

☐ **Non-Smoker:** I certify as a true fact that I have **NOT** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or any kind of tobacco products or substitutes such as nicotine gum, nicotine patches or anti-smoking medication (Zyban) in the past twelve (12) month period immediately preceding the date written beside my signature below.

☐ **Smoker:** I certify as a true fact that **I have** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or any kind of tobacco products or substitutes such as nicotine gum, nicotine patches or anti-smoking medication (Zyban) in the past twelve (12) month period immediately preceding the date written beside my signature below.

I understand and agree that the premiums charged for my insurance coverage are based in part on the statements given by me on this form. I certify that the statements are accurate, true and complete in all respects. In the event that any such statement is inaccurate, untrue or incomplete in any respect, I understand and agree that all Optional and Supplementary Life insurance coverage is voidable by the insurer. I further agree that in such event the insurer's liability is limited to paying to the designated beneficiary/beneficiaries the amount of any premium I paid for insurance.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

SECTION #4: LIFE INSURANCE BENEFITS SELECTION

EMPLOYEE BASIC TERM LIFE and OPTIONAL LIFE INSURANCE

Indicate the Plan Option selection by placing a ✔in the appropriate box

THE FOLLOWING STATEMENTS APPLY TO PLAN OPTIONS 2, 3 AND 4.

I understand that failure to apply for Plan Options 2, 3 or 4 at this time will require evidence of insurability, satisfactory to the insurer, should I later decide to opt for these benefits.

I am also aware of the Retirement Insurance coverage applicable to me as an individual.

PLAN OPTION:	#1 ☐	#2 ☐	#3 ☐	#4 ☐
Basic Term Insurance	150%	175%	175%	175%
Additional (Optional) Term Insurance	Nil	25%	75%	125%
TOTAL INSURANCE	**150%**	**200%**	**250%**	**300%**

Note: All amounts of insurance are rounded upward to the nearest $1,000

EMPLOYEE SUPPLEMENTARY LIFE INSURANCE

☐ Coverage NOT Requested | ☐ Amount Applied For: $_____ *Coverage is available in units of $10,000 to a maximum of $250,000*

NOTE: ***Application is subject to satisfactory evidence of insurability. Employee must complete a health questionnaire and attach it to this enrollment form***

SPOUSE OPTIONAL LIFE INSURANCE

☐ Coverage NOT Requested | ☐ Amount Applied For: $_____ *Coverage is available in units of $10,000 to a maximum of $250,000*

NOTE: ***Application is subject to satisfactory evidence of insurability. Spouse must complete a health questionnaire and attach it to this enrollment form***

SPOUSE NAME:	GENDER:	DATE OF BIRTH
First Name _____ **Middle Name** _____ **Last Name** _____	☐ MALE ☐ FEMALE ☐ OTHER	*(MM/YY/DD)*

SPOUSE DECLARATION OF SMOKING HABITS: *Please check off the appropriate box below:*

☐ **Non-Smoker:** I certify as a true fact that I have **NOT** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or any kind of tobacco products or substitutes such as nicotine gum, nicotine patches or anti-smoking medication (Zyban) in the past twelve (12) month period immediately preceding the date written beside my signature below

☐ **Smoker:** I certify as a true fact that **I have** smoked cigarettes, e-cigarettes, cigarillos, cigars, a pipe or any kind of tobacco products or substitutes such as nicotine gum, nicotine patches or anti-smoking medication (Zyban) in the past twelve (12) month period immediately preceding the date written beside my signature below.

I understand and agree that the premiums charged for my insurance coverage are based in part on the statements given by me on this form. I certify that the statements are accurate, true and complete in all respects. In the event that any such statement is inaccurate, untrue or incomplete in any respect, I understand and agree that the Spousal Optional Life insurance coverage is voidable by the insurer. I further agree that in such event the insurer's liability is limited to refunding the amount of any premium paid for insurance on my behalf.

SPOUSE SIGNATURE: _____ **DATE:** _____

GROUP BENEFITS ENROLLMENT FORM

SECTION #5: BENEFICIARY DESIGNATION

Please PRINT your beneficiary's name in FULL. If more than one beneficiary is named, indicate the percentage for each beneficiary (if no percentage is indicated for multiple beneficiaries we will assume equal shares for each). If your beneficiary is under the age of majority, a trustee must be appointed.

PRIMARY BENEFICIARY:

First Name	Middle Name	Last Name	Under Age 18	Relationship	% Share
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

Unless otherwise stipulated and unless prohibited by law, the designation of any beneficiary is revocable. The designation above will supersede any prior beneficiary designation. Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: ☐ REVOCABLE

CONTINGENT BENEFICIARY:

In the event that there are no surviving Primary Beneficiary at the time of my death, the Contingent Beneficiary(ies) listed below will be entitled to receive the proceeds of all life insurance policies insured.

First Name	Middle Name	Last Name	Under Age 18	Relationship	% Share
			☐ Yes ☐ No		
			☐ Yes ☐ No		

Unless otherwise stipulated and unless prohibited by law, the designation of any beneficiary is revocable. The designation above will supersede any prior beneficiary designation. Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: ☐ REVOCABLE

TRUSTEE NOMINATION:

Identify a trustee when appointing a minor as a beneficiary for your life insurance coverage under The MEARIE Group program. You can name an individual (an "administrator" or "trustee") other than the child's parents, or other legal guardian when applicable, to manage the proceeds on their behalf until the child reaches the age of majority (age 18 in Ontario). Before designating a trustee, we recommend you consult with a legal advisor and with the proposed trustee.

If you are separated or divorced you can name someone other than the child's other parent as the administrator/trustee which is allowable unless the minor beneficiary resides in Quebec. Quebec courts have ruled that when a death benefit under a life insurance policy is payable to a minor beneficiary, it must be paid to the child's parent(s) (or other legal guardian when applicable) and not to any other administrator/trustee named under the life insurance policy.

Full Name: _____ **Relationship to Plan Member:** _____

Unless otherwise stipulated and unless prohibited by law, the designation of any beneficiary is revocable. The designation above will supersede any prior beneficiary designation. Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: ☐ REVOCABLE

SECTION #6: HEALTH AND DENTAL BENEFITS SELECTION

I wish to participate in: **Health:** ☐ **Single Coverage** ☐ **Family Coverage** ☐ **Waiving Coverage ***
Dental: ☐ **Single Coverage** ☐ **Family Coverage** ☐ **Waiving Coverage ***

DECLARATION OF WAIVING COVERAGE:

☐ I am waiving coverage for **myself, my spouse and my dependent children.** We have similar coverage under my spouse`s group insurance plan.
We request **NOT** to be covered for: ☐ **Health Care** ☐ **Dental Care**

☐ I am waiving coverage for my **spouse and dependent children only.** We have similar coverage under my spouse`s group insurance plan.
My **spouse and dependent children** are **NOT** to be covered for: ☐ **Health Care** ☐ **Dental Care**

CO-ORDINATION OF BENEFITS:

If your spouse is covered for health and/or dental under their employer's plan and you wish to waive coverage **OR** coordinate benefit coverage under his/her plan, provide details below.

BENEFIT	COVERAGE		NAME OF SPOUSE'S EMPLOYER	NAME OF SPOUSE'S INSURANCE COMPANY	POLICY NUMBER
	Single	Family			
Health	☐	☐			
Dental	☐	☐			

If you lose coverage under your spouse's plan, you must apply for coverage under this program within 31 days of the loss of coverage. If you do not apply within 31 days you and your dependents may be required to provide proof of good health acceptable to the insurance company. If approved, coverage will commence on the date the insurer approves coverage.

SECTION #7: DEPENDENT INFORMATION

Dependent Relationship	First Name | Middle Name | Last Name	Gender	Date of Birth MM DD YY	Dependent Student*	Handicapped Child
SPOUSE		☐ MALE | ☐ FEMALE | ☐ OTHER		☐ YES | ☐ NO	☐ YES | ☐ NO
CHILD		☐ MALE | ☐ FEMALE | ☐ OTHER		☐ YES | ☐ NO	☐ YES | ☐ NO
CHILD		☐ MALE | ☐ FEMALE | ☐ OTHER		☐ YES | ☐ NO	☐ YES | ☐ NO
CHILD		☐ MALE | ☐ FEMALE | ☐ OTHER		☐ YES | ☐ NO	☐ YES | ☐ NO

***NOTE: If dependent child is a full-time student, under age 25, indicate the name of university/college being attended including dates of attendance.**

Name of University/College: _____ **Date Attending FROM:** _____ **TO:** _____

SECTION #8: AUTHORIZATION

EMPLOYEE: I hereby apply for the Group Insurance Benefit(s) for which I am, or may later become eligible for and authorize the necessary deductions, if any, to be made by my employer from my earnings. I am authorized to disclose information about my spouse and dependents in order to enroll them under the plan. If the Member Identification Number is my Social Insurance Number, I authorize The MEARIE Group, its representatives and any service providers working with The MEARIE Group to use or exchange information collected in this form to underwrite, administer and adjudicate claims. Furthermore, I also authorize the use of such number for tax reporting identification and the administration of my benefits. I certify that the information given is true, correct and complete to the best of my knowledge.

Signature:_____ **Date:**_____

EMPLOYER: The undersigned, on behalf of the employer, hereby certifies that to the extent that available records and information permit, the statements on this form are true and complete and no material information has been omitted or withheld.

Signature:_____ **Date:**_____

At The MEARIE Group, we recognize and respect every individual's right to privacy. We use the personal information provided to determine your eligibility for coverage and administer the group benefit plan.