# EMPLOYEE BENEFIT PROGRAM
# ENROLLMENT FORM

## GENERAL INFORMATION (Part A)

| | | | |
|---|---|---|---|
| **EMPLOYER NAME** | | | |
| **DIVISION NUMBER** | **CLASS** | **IDENTIFICATION NUMBER** | |
| **EMPLOYEE NAME** | | | |
| Last Name | First Name | Middle Name | |
| Date of Hire (YY/MM/DD) | Gender ☐ Male ☐ Female | Date of Birth (YY/MM/DD) | Waive Waiting Period ☐ Yes ☐ No *(A letter requesting to waive the waiting period must accompany this form)* |
| Earnings ☐ Hourly ☐ Weekly $ ☐ Monthly ☐ Annual | No. Hours Per Week | Marital Status ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | Province of Residence |
| Mailing Address (Optional) | | | |
| Street | City | Province | Postal Code |

## EMPLOYEE LIFE INSURANCE COVERAGE ELECTIONS (Part B) *Complete if Applicable*

**BASIC TERM LIFE AND EMPLOYEE OPTIONAL TERM LIFE**

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 **OR** ☐ 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.***

**DECLARATION OF SMOKING HABITS:** *Please complete for all options of Employee Life Insurance Coverage Elections by checking 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 used marijuana 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 used marijuana 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:**

## BENEFICIARY INFORMATION (Part C)

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.

| 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

**Please complete reverse side**

**SPOUSE OPTIONAL LIFE INSURANCE *(*Part D) *Complete if Applicable***

☐ Coverage Not Requested **OR** ☐ 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. Your spouse must complete a health questionnaire and attach it to this enrollment form.***

| **Spouse`s Name:** **First Name** **Middle Name** **Last Name** | ☐ Male ☐ Female | Date of Birth (YY/MM/DD) |
|---|---|---|

**DECLARATION OF SPOUSE`S 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 used marijuana 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 used marijuana 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`S SIGNATURE:** **DATE:**

**EXTENDED HEALTH DENTAL COVERAGE SELECTIONS (Part E)**

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

***Declaration for Waiving Coverage: *Please check off the appropriate box below:***

☐ 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**

**OR**

☐ 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**

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, please provide details below.

**COORDINATION OF COVERAGE AND/OR WAIVER OF COVERAGE DETAILS**

| 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.***

**DEPENDENT INFORMATION (Part F) – *Please complete this section if applying for Dependent Life Insurance or family Extended Health and/or Dental Coverage***

| Dependent Relationship | First Name Middle Name Last Name | Gender | Date of Birth Year Month Day | Dependent Student* | Handicapped Child |
|---|---|---|---|---|---|
| SPOUSE | | ☐ Male ☐ Female | | | |
| Child | | ☐ Male ☐ Female | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Child | | ☐ Male ☐ Female | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Child | | ☐ Male ☐ Female | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Child | | ☐ Male ☐ Female | | ☐ 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**

**AUTHORIZATION (Part G)**

**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.