

Enrolment Form



Please PRINT clearly

1 Member Details

Contract Number 35855	Division	Employer
<input type="checkbox"/> New member <input type="checkbox"/> Re-hire	Date of Hire/Re-hire (yyyy/mm/dd)	Member ID number: ICBA to assign and advise
Effective date of coverage (yyyy/mm/dd) *First of month following 3 months employment	Class 101 <input type="checkbox"/> Standard Plan 102 <input type="checkbox"/> Enhanced plan	
Member name (first, middle initial, last)		<input type="checkbox"/> Male <input type="checkbox"/> Female
Member address (street number and name, apartment or suite)		
Phone	City	Province Postal Code
Date of birth (yyyy/mm/dd)	Language <input type="checkbox"/> English <input type="checkbox"/> French	Member's province of residence Member's province of employment
Email Address		Occupation
Salary \$	Basis <input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Semi-monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly (Hrs./Wk. _____) Please specify
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Civil Union <input type="checkbox"/> Separated	<input type="checkbox"/> Widowed <input type="checkbox"/> Common Law: Date of cohabitation _____ Dependent Status <input type="checkbox"/> Single <input type="checkbox"/> Family

2 Spouse Details

Name (first, last)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (yyyy/mm/dd)
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Is your spouse covered for Extended Health Care and/or Dental benefits by his/her employer's plan?

Yes No If Yes, please indicate spouse's coverage:

Dental Family Single

Extended Health Care Family Single Name of Carrier: _____

3 Children Details

Canadian Life and Health Insurance Association Guidelines (CLHIA) state:

1. A spouse must first claim from his/her own employer's plan.
2. Covered children must first claim from the plan covering the parent with the earlier date of birth in the year.

Name (first, last)	Date of birth (yyyy/mm/dd)	Gender	Student*
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

* **Definition of a student is a child age 21 or over but under age 25 who is a full-time student attending an educational institution recognized by Canada Revenue Agency, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support.**

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Confirmation of school attendance (dependent children who have reached the first age limit)

Given name(s)	Name of educational institution attended on a full time basis	Attendance Period		Telephone no. of institution
		Start (YYYY/MM/DD)	End (YYYY/MM/DD)	
				()
				()
				()

The Standard Life Assurance Company of Canada reserves the right to confirm student status with the educational institute

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Revocable beneficiary nomination

Any changes to the beneficiary must be initialed by the Member.

Beneficiary's name (first, last)	Relationship to Member	Percent Share

Only complete Trustee Nomination section if nominating beneficiaries who are minors (other than Quebec).

Please note that according to legal requirements, The Insurer cannot pay benefits to beneficiaries who are minors. A trustee for minor children must be designated, except in Quebec.

Beneficiary Trustee Nomination

Any payments becoming due during the minority of the minor(s) to be made to

_____ as Trustee, or failing such Trustee to the duly appointed guardian of such minor child as Trustee. Payment to said Trustee shall discharge the company.

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Authorization and signature

You must be authorized to disclose information about your spouse and dependents in order to enroll them in the Plan.

By enrolling in this Plan, I authorize the following:

- The underwriting Insurance Company, its agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims,
- My plan sponsor to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required

I authorize my employer, the policyholder, the plan administrator, The Standard Life Assurance Company of Canada or their reinsurers, their respective agents to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any under this plan.

In the case of death, I expressly authorize my employer, the policyholder, the beneficiary, heir or liquidator of my estate to provide The Standard Life Assurance Company of Canada, when required by the latter, with all the information and authorizations permitting the assessment of the claim and the collection of evidence.

A photocopy of this consent is valid as the original if it is used for information-sharing purposes.

All information in this form is true and complete.

Member Signature X	Date (yyyy/mm/dd)
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