MROO RETIREE BENEFITS ENROLLMENT FORM
2011 HEALTH AND DENTAL CARE PLANS, ANNUAL TRAVEL INSURANCE

Please review How to Enroll instructions and the Privacy and Confidentiality Statements prior to completing this form.

CHOOSE YOUR PLAN (2011 Monthly Rates)

Plan I – Semi-Private Hospital

- ○ Retiree $39.05
- ○ Retiree & Spouse $59.50

Plan II – Semi-Private Hospital and Extended Health Care

- ○ Retiree $88.90
- ○ Retiree & Spouse $144.30
- ○ Add Annual Travel Insurance* Single: $25.00, *plus applicable tax*
  Couple: $50.00, *plus applicable tax*

Plan III – Semi-Private Hospital, Extended Health and Dental Care

- ○ Retiree $150.35
- ○ Retiree & Spouse $258.70
- ○ Add Annual Travel Insurance* Single: $25.00, *plus applicable tax*
  Couple: $50.00, *plus applicable tax*

** If selected, the Annual Travel Insurance Plan premium will be added to the Health and Dental Plan premium you have selected above. This combined amount will represent the total premium to be paid each month.The Annual Travel Insurance enrollment must match the Health and Dental Care Plan enrollment – i.e., if you enroll in a Retiree & Spouse Health and Dental Plan, the Annual Travel Insurance Plan will cover both you and your spouse, and the additional premium will be at the "Couple" rate.*

RETIREE INFORMATION

Retiree's Name (last) ________ (first) ________

Address ________

Unit No. ________ City /Town ________

Province/Territory ________ Postal Code ________

Phone (area code) ________ Email ________

Birthdate (YYYY/MM/DD) ________ Gender ○ M ○ F

Retirement Date (YYYY/MM/DD) ________

Retiree's former employer ________

Date employer-sponsored health and dental care coverage ceased (YYYY/MM/DD) ________

Effective date requested for new coverage (YYYY/MM/DD) ________

Date of termination of an existing or previous annual travel insurance plan (YYYY/MM/DD) ________

Name of insurance company that provided the annual travel insurance plan ________

Are you an OMERS pensioner? ○ Yes ○ No

Did you have Extended Health Care coverage immediately prior to retirement? Retiree ○ Yes ○ No Spouse ○ Yes ○ No

Did you have Dental Care coverage immediately prior to retirement? Retiree ○ Yes ○ No Spouse ○ Yes ○ No

SPOUSAL INFORMATION

Please complete for spousal coverage:

Spouse's Name (last) ______ (first) ______

Birthdate (YYYY/MM/DD) ______ Gender ○ M ○ F

Date previous health and dental care coverage ceased (YYYY/MM/DD) ______

PAYMENT OF PREMIUM – PERSONAL PRE-AUTHORIZED DEBIT AGREEMENT

I/We authorize ENCON Group Inc. to withdraw my/our monthly premium (as determined by my/our plan choices on the previous page of this Enrollment Form) from my/our bank, trust company or credit union account on the first banking day of every month and have enclosed a blank personal cheque marked "VOID". I/We have read and understand that:

- I/We may cancel my/our Personal Pre-authorized Debit Agreement at any time, subject to providing written 30-days notice to ENCON Group Inc. Retiree Benefits, 1900–11 King Street West, Toronto ON M5H 4C7.
- I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with my/our Personal Pre-authorized Debit Agreement. To obtain more information on my/our recourse rights, I should contact my/our financial institution or visit www.cdnpay.ca.

Monthly withdrawals are to be made from this Account Number ______

Signature of Account Holder ______ Date ______

Signature of Joint Account Holder ______ Date ______
(if applicable)

DECLARATION (PLEASE READ AND SIGN)

I/We acknowledge that the statements contained herein are true and together with any other forms signed by me/us in connection with this Enrollment form the basis for my/our coverage. I/We have read and agree with the Privacy and Confidentiality Statements on pages 10 and 14 of the MROO Health and Dental Care Plans/Annual Travel Insurance Plan brochure. I/We understand my/our coverage will begin on the later of the Effective Date requested or the date my/our Enrollment Form and void cheque are received by ENCON. If hospitalized on that date, coverage will not begin until the date of discharge from hospital. I/We further understand that if I/we am/are enrolled in an existing annual travel insurance plan, coverage under the MROO Annual Travel Insurance Plan will begin on the termination date of the existing annual plan.

Signed at City/Town ______ Province/Territory ______

Retiree's Signature ______ Spouse's Signature ______
(if applying for coverage)

Date signed (YYYY/MM/DD) ______

HOW DID YOU HEAR ABOUT OUR PROGRAM?

○ Employer ○ OMERS ○ MROO mailing ○ Word of mouth ○ Union/Association ○ MROO event/newsletter

ENROLL TODAY!

Once you have completed and printed this form, please sign, date and mail to ENCON Group Inc. along with your void cheque. If you have any questions about coverage or about completing your enrollment form, please contact our MROO Insurance specialists at: **Toll free number 1-800-363-7861 / Email mroo@encon.ca.**

ENCON Group Inc.
Retiree Benefits, New Business
1900 – 11 King Street West
Toronto ON M5H 4C7