


Quebec residents: before completing this section, please refer to the « Bill 33 » document on reverse

ADMINISTRATIVE INFORMATION

Employer/Policyholder name		Group No.	Division No.	Class	Department
Employee's last name		First Name		Employee No.	
Date of birth (YYYY - MM - DD)	Sex : <input type="checkbox"/> M <input type="checkbox"/> F	Civil status : <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common-law spouse ⇒ Cohabitation since _____			
Address (No. / Street / Apt.)					
City		Province	Postal code	Telephone	
Date of full-time employment (YYYY - MM - DD)	Date of eligibility for Insurance (YYYY - MM - DD)	Occupation		Earnings : \$ _____ <input type="checkbox"/> Annual <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly ⇒ # hours/week _____	
<input type="checkbox"/> YES, I would like to receive my claims reimbursements directly into my bank account.					
Branch		Bank	Account number		
 Branch Bank Account number					

REQUIRED COVERAGE AND INFORMATION ON SPOUSE AND/OR CHILDREN

Health care:	<input type="checkbox"/> Single <input type="checkbox"/> Single parent <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Opt-out ⇒ Reason : _____
Dental care:	<input type="checkbox"/> Single <input type="checkbox"/> Single parent <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Opt-out ⇒ Reason : _____
Dependent Life benefit: (if it is part of your plan)	Do you want to cover your dependent for Dependent Life benefit ? <input type="checkbox"/> Yes <input type="checkbox"/> No (This benefit may be mandatory with some insurers if you have eligible spouse and/or children)
Optional benefits: If offered under your plan and under its conditions. Subject to insurer's approval. Evidence of insurability must be completed and returned to AGA.	Optional Life insurance : <input type="checkbox"/> Amount requested : \$ _____
	Optional Dependent Life benefit : <input type="checkbox"/> Amount requested : \$ _____
	Optional Accidental death and dismemberment benefit : <input type="checkbox"/> Amount requested : \$ _____

SPOUSE AND/OR CHILDREN IDENTIFICATION

The Dependent Life benefit coverage, if part of your plan, may be mandatory with some insurers if you have eligible spouse and/or children. You must indicate all information regarding your eligible spouse and/or children even if you choose a "Single" coverage or if you choose to "Opt-out".

	Last name	First name	Sex		Date of birth (YYYY - MM - DD)	21 years of age or more, please specify:		Are the spouse/children covered by another plan ?				
			M	F		Full-time student	Handicapped	Health care Yes No		Dental care Yes No		
Spouse			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 1			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 2			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 3			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 4			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 5			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 6			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 7			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered « Yes » to the question : « Are your children covered by another plan ? », please confirm details on back. This information is necessary to apply the rules for the coordination of benefits.

BENEFICIARY DESIGNATION

Beneficiary's last name	First name	Date of birth (YYYY - MM - DD)	Relationship

For Quebec participants only

The designation of your spouse (married or civil union) as beneficiary is irrevocable unless otherwise specified. If the beneficiary is shown as irrevocable, his/her consent will be required to change it. If spouse is beneficiary, designation is: **revocable** **irrevocable**
There might be issues with respect to the appointment of a **trustee** as beneficiary. You should consult a legal advisor regarding this matter.

AUTHORIZATION AND SIGNATURE

Please take note of the « Notice regarding personal information confidentiality » on reverse

I hereby request coverage under my employer/policyholder's group insurance plan subject to the contract terms and conditions and authorize my employer/policyholder to deduct the required contributions from my earnings. I also authorize my employer/policyholder, the insurer and their respective representatives and mandataries to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any, under this plan.

Employee's signature	Date
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Children covered by another plan – Please provide the following details :

Indicate for which child the following applies – Child # _____

Health care	Dental care
<input type="checkbox"/> Coverage by the plan of current spouse <input type="checkbox"/> Coverage by the plan of an educational institution <i>If the parents are separated, divorced or not living together :</i> <input type="checkbox"/> Coverage by the plan of the other parent <input type="checkbox"/> Coverage by the plan of the spouse of the other parent <input type="checkbox"/> Coverage by the plan of the other parent and the spouse of the other parent Is this parent the sole custodial? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of birth of the other parent (YYYY/MM/DD) : _____	<input type="checkbox"/> Coverage by the plan of current spouse <input type="checkbox"/> Coverage by the plan of an educational institution <i>If the parents are separated, divorced or not living together :</i> <input type="checkbox"/> Coverage by the plan of the other parent <input type="checkbox"/> Coverage by the plan of the spouse of the other parent <input type="checkbox"/> Coverage by the plan of the other parent and the spouse of the other parent Is this parent the sole custodial? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of birth of the other parent (YYYY/MM/DD) : _____

Indicate for which child the following applies – Child # _____

Health care	Dental care
<input type="checkbox"/> Coverage by the plan of current spouse <input type="checkbox"/> Coverage by the plan of an educational institution <i>If the parents are separated, divorced or not living together :</i> <input type="checkbox"/> Coverage by the plan of the other parent <input type="checkbox"/> Coverage by the plan of the spouse of the other parent <input type="checkbox"/> Coverage by the plan of the other parent and the spouse of the other parent Is this parent the sole custodial? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of birth of the other parent (YYYY/MM/DD) : _____	<input type="checkbox"/> Coverage by the plan of current spouse <input type="checkbox"/> Coverage by the plan of an educational institution <i>If the parents are separated, divorced or not living together :</i> <input type="checkbox"/> Coverage by the plan of the other parent <input type="checkbox"/> Coverage by the plan of the spouse of the other parent <input type="checkbox"/> Coverage by the plan of the other parent and the spouse of the other parent Is this parent the sole custodial? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of birth of the other parent (YYYY/MM/DD) : _____

Initials : _____

**QUEBEC RESIDENTS ONLY
BILL 33 - « DID YOU KNOW ... »**

- ✓ On January 1st, 1997, Bill 33 (Quebec Universal Drug Plan) became effective for all Quebec residents.
- ✓ All Quebec residents under 65 years of age that have access to a group insurance plan, are obliged to join the group plan. If a person is covered by another group plan or if a person is covered by a spouse's group plan, proof of such coverage must be filed with your employer.
- ✓ On the group insurance application form with your employer, you are obliged to insure all eligible dependents, spouse and children, unless these dependents are already covered by another group plan.
- ✓ Your eligible dependents cannot be insured with R.A.M.Q. (Quebec Universal Drug Plan) if you are covered by your employer's group plan, with the exception of a spouse, aged 65 years and over.
- ✓ When filing your Quebec tax return, you will be asked if you have met the requirements according to this law.

NOTICE REGARDING PERSONAL INFORMATION CONFIDENTIALITY

As group insurance administrators, we are required to collect and maintain on file certain personal data concerning yourself. We are aware that this is an important responsibility and this is why we consider the personal information protection a priority.

The subject of Your File – *The subject-matter of your file as established at our firm bears the title “ Group Insurance (Sales, Administration and Services) ”. The personal information concerning you is collected in this file and is kept secure under the highest standards of confidentiality.*

Confidentiality – *We only collect relevant information needed to constitute this file for purposes of allowing us to carry out our assignment. Access to this file is limited to the firm's employees, representatives, agents and suppliers who require this information to successfully accomplish their duties. Information contained in this file cannot be disclosed without your consent; any disclosure must comply with provisions under the Act respecting the protection of personal information in the private sector.*

Access – *If you wish to have access to your file, you must send a request by e-mail at: info@gfaga.com or communicate with us at numbers mentioned below.*

Updates and corrections – *Please keep us informed regarding any changes in information contained in this file and, if required, indicate to us in writing any correction needed to ensure accuracy.*

**For further information, please do not
hesitate to contact Customer Service
at the following numbers :**

Montreal area : 514-935-5444
Elsewhere in Quebec : 1 800 363-6217
Fax : 514-935-1147