APPLICATION FOR GROUP INSURANCE BENEFITS

TO BE COMPLETED BY THE EMPLOYEE

LAST NAME	FIRST NAME AND INITIAL	GENDER M / F	DATE OF BIRTH Day	Month	Year	EMPLOYEE SOCIAL INSURANCE NUMBER
EMPLOYEE						
SPOUSE*						
DEPENDENT CHILDREN						Do you wish to apply for Optional Life Insurance Coverage? Yes ☐ No ☐
						Language English ☐ French ☐

EMPLOYEE HOME ADDRESS (Number and Street)	CITY	PROV	POSTAL CODE	HOME TELEPHONE NUMBER
		MB		

***If Applicant & Spouse are not legally married, provide commencement date of cohabitation:** _____, _____

PLEASE NOTE: After 1 year of co-habitation, a Common-Law Spouse MUST be enrolled in the plan.

MEDICAL & DENTAL COVERAGE

I understand that my participation in this group insurance plan is **COMPULSORY** and that I must enroll myself and my spouse/dependent children within 31 days of becoming eligible. I may only waive Medical and/or Dental coverage for myself and my spouse/dependent children if insured for these benefits under my spouse's plan. If coverage is later terminated under my spouse's plan, I must enroll myself and my spouse/dependent children within 31 days of such termination. I may only change the coverage I am currently applying for if there is a change in my family status or my spouse's coverage is terminated.

I hereby apply for the following coverage:

MEDICAL Single ☐ Family ☐ Waive ☐

DENTAL Single ☐ Family ☐ Waive ☐

Spouse's Current Coverage				Spouse's Employer	Spouse's Insurer
MEDICAL	None ☐	Single ☐	Family ☐		
DENTAL	None ☐	Single ☐	Family ☐		

REVOCABLE BENEFICIARY DESIGNATION

Should you die while your Group Life Insurance and Accidental Death and Dismemberment benefits are in force, the beneficiaries you designate below will receive the insurance proceeds. If you name more than one person, you must show what percentage of the payout should go to each person. The total of these percentages must be 100%. You can change your beneficiaries at any time by completing a change form available from the plan administrator.

BENEFICIARY LAST NAME	FIRST NAME	DATE OF BIRTH (M/D/Y)	RELATIONSHIP TO YOU	PERCENTAGE PAYABLE TO EACH
			TOTAL	100%

(If you wish to name more than 4 beneficiaries, please list them on a separate page and attach to this application)

In the absence of a new beneficiary designation made by me and duly filed with the administrator of this plan, the above beneficiary designation(s) shall be valid under the current group insurance contract(s) and any successor contract(s) that may replace them.

DECLARATION APPOINTING TRUSTEE: (Note: For any beneficiary under legal age today, you must appoint an adult as trustee for them.) I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under legal age, and payment to the above Trustee shall fulfill the Insurance Company's obligations. I also hereby authorize the Trustee, on behalf of the beneficiary, to spend all or any portion of the funds and/or income earned from them for the care, maintenance, education, etc. of the beneficiary.

STATEMENT OF APPLICANT: I hereby apply for insurance under the policies of group insurance arranged by my employer for which I am eligible, subject to all the terms, conditions, and provisions of such policies. I certify that all information contained hereon is correct and complete. I hereby authorize payroll deductions if required. I hereby consent to the use of my social insurance number for administration purposes, the collection, use, retention and disclosure of my personal information and that of my dependents and beneficiaries as required by my employer, insurance companies, plan administrators and/or health care professionals for enrollment, underwriting, plan and claim administration and product development and recommendation purposes. I understand that I may revoke my consent at any time, however, if I do so the coverage may be denied or rescinded.

Date: _____ **Employee's signature:** _____

TO BE COMPLETED BY THE EMPLOYER

Sport Group		Full-Time Employment Date Day / Month / Year	Eligibility Date Day / Month / Year
Occupation		Certificate Number	Class
Earnings $ _____ per ☐ Year ☐ Week ☐ Month ☐ Hour	Hours per Week	Completed for the Employer by: Date _____ Signature _____	