



Empire Life™

GROUP ENROLMENT FORM

Group Number

Division

Certificate

Basic Employee Information

Given Name: \_\_\_\_\_
Last Name: \_\_\_\_\_
Date of Birth: \_\_\_\_\_ (Day/Month/Year)

To be Completed by Employer

Name of Employer/Division: \_\_\_\_\_
Payroll Number: \_\_\_\_\_ applicable if certificate is payroll number
Date Employed Part Time: \_\_\_\_\_ (Day/Month/Year)
Date Employed Full Time: \_\_\_\_\_ (Day/Month/Year)
Class: \_\_\_\_\_
Hours Worked Per Week \_\_\_\_\_

Table with 3 columns: Amount, Per (week, bi-weekly, annual etc.), Hrs/Week. Rows for Salary, Bonus, Commission.

Effective Date of Coverage: \_\_\_\_\_ Department: \_\_\_\_\_
Employer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If TOTAL REFUSAL of Coverage is applicable to this employee do not complete this section. Complete the Section Coverage Refusal/Waiver - Understanding the Choice - on REVERSE side of this form

To be Completed by Employee \* Provincial Health Care Coverage in place (i.e. RAMQ, OHIP, BC Pharmacare) Y / N

Male [ ] Language: [ ] English [ ] French Province of Residence: \_\_\_\_\_
Female [ ] Occupation: \_\_\_\_\_ Do you have a Spousal Dependant? Y / N
Do you have a Child Dependant? Y / N

Beneficiary Designation

Given Name: \_\_\_\_\_ Given Name: \_\_\_\_\_
Last Name: \_\_\_\_\_ Last Name: \_\_\_\_\_
Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_
Percentage Split: \_\_\_\_\_ Percentage Split: \_\_\_\_\_

If Beneficiary is a minor, a trustee must be appointed

Trustee Name: \_\_\_\_\_
Type of Designation
(Designation Signature Date is the date the Group Enrolment Form was signed.)
Revocable (Consent of Beneficiary is not required to change designation) [ ]
Irrevocable (Consent of Beneficiary is required to change designation) [ ]
Where Quebec Law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: [ ] revocable

Dependant Information (spouse and eligible dependants to be covered)

Table with 7 columns: Given Name, Last Name, Relationship, D / M / Y Date of Birth, Male/Female, Handicap (Y/N), Overage of 22 (Y/N) See Below. Row 1: Spouse.

\_\_\_\_\_ is a full time student. Start date \_\_\_\_\_ End Date \_\_\_\_\_ School Name \_\_\_\_\_

If out of Canada/USA provide Country Name: \_\_\_\_\_ Departure Date \_\_\_\_\_

\_\_\_\_\_ is an Overage Handicapped Dependant (Complete Overage Handicapped Form and submit to Empire Life)

**Coverage Refusal/Waiver - Understanding the Choice**

In respect of total Refusal of, or Waiver of (see Refusal and Waiver options below), any coverage under this Group Plan, I acknowledge that I have been offered the benefits of my employer's Group Insurance Plan with The Empire Life Insurance Company and benefits provided by this Plan have been fully explained to me. I further acknowledge that I am forfeiting (as indicated below) all my rights and privileges in respect to such benefits. I understand that if I apply for refused or waived coverage in the future, I may be requested to provide evidence of insurability at my own expense.

**Total Refusal of Coverage**

(Only available under plans with Non-Mandatory participation requirements. See your Plan Administrator for details)

I waive total coverage for me and my dependants, if any.

**Waiver of Extended Health and/or Dental Coverage (Spousal Opt Out) OR Co-ordination of Benefits**

I, and/or my dependants have coverage with my spouse's group insurance plan and I wish to waive the following coverage's OR Co-ordinate Benefits. Note: Family coverage will be provided until spouses Insurance carrier information is provided.

	Name of Other Insurer (Spouses)	Indicate Other Insurer Coverage Type Single or Family	Waive coverage for myself & dependants (choose Waive)	OR Waive Coverage for my dependants only (choose Single)	OR Co-ordination of Benefits (Choose Family)
Extended Health			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Banking Information**

We provide the convenience of electronic deposit of Dental claim payments into your bank account. PLEASE ATTACH A VOID CHEQUE to use this service.

**Authorization**

- I understand that the above personal information concerning me and my dependants is being collected by The Empire Life Insurance Company (Empire Life) for the object and purpose of:
    - assessing the risk on a continuing basis and considering whether to issue or renew a group policy of insurance under which I might be or become insured;
    - determining the premium payable for such insurance;
    - assessing my eligibility for coverage and the nature and amounts of such coverage;
    - assessing any claim made by me, my dependants or beneficiaries
 and I authorize Empire Life, its employees, agents, representative to collect this information for these purposes and to disclose this information to Empire Life agents, representatives, health care providers, other insurance companies or benefit service providers, reinsurers and third-party service providers insofar as such disclosure is required in order to achieve these purposes.
  - I understand that this information will be maintained in a file by Empire Life and that only Empire Life employees, agents, representatives, reinsurers, or any other person authorized by me will have access to the file(s) when necessary for achieving the purpose of the file. I also understand that I am entitled to consult the file and, when applicable, have it corrected, and that I can exercise this right by contacting the Empire Life Head Office.
  - I authorize the policyholder/plan administrator to communicate personal information concerning me and my dependants to Empire Life in order that my personal information be updated as required for achieving the purpose(s) of the file(s)
  - I also authorize Empire Life to release to the policyholder/plan administrator and agent of record any group statistical information that may include information concerning claims paid on my behalf or on behalf of my eligible dependants (other than specific details relating to medical condition(s)) for the purpose of negotiating policy renewals, premiums and benefits management.
  - If applying for my spouse and/or dependants, this authorization also applies to the collection use and communication of their personal information, and I confirm that I am authorized to act on their behalf.
  - I hereby apply for benefits, for which I am or may become eligible and authorize payroll deductions, if required.
  - I confirm that a photocopy or electronic copy of this enrolment form and authorization is as valid as the original.
- I hereby declare that the above answers and statements are full, complete and true and agree and understand that these answers are material to the risk and form part of the application and consideration for the insurance applied for.

Date \_\_\_\_\_

Employee's Signature \_\_\_\_\_