

New Plan Member Group Insurance Application

Section A

GROUP POLICY NUMBER		DIVISION	
PLAN MEMBER'S NAME (PLEASE PRINT)			CERTIFICATE NUMBER
FIRST	MIDDLE	LAST	
PROVINCE OF RESIDENCE	DATE OF BIRTH month day year	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> PARTNERED (COMMON LAW) <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOW(ER) <input type="checkbox"/> DIVORCED <input type="checkbox"/>
FULL NAME OF BENEFICIARY(IES) - MUST PROVIDE FIRST AND LAST NAME		BENEFICIARY IS YOUR <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARTNERED (COMMON LAW) <input type="checkbox"/> MOTHER <input type="checkbox"/> OTHER (SPECIFY)	MARITAL STATUS <input type="checkbox"/> CHILD(REN) <input type="checkbox"/> FATHER <input type="checkbox"/> FULL NAME OF TRUSTEE (IF BENEFICIARY IS UNDER 18 YEARS OF AGE)
NUMBER OF DEPENDANT CHILDREN			
NOTE: For Quebec residents, designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary. I elect to make my spouse beneficiary designation: <input type="checkbox"/> Revocable			

Section B

HEALTH AND/OR DENTAL COVERAGE REQUIRED (see instructions on reverse)

Benefits (please check appropriate boxes for Options)

1. I need Health Dental for myself only, as I have no eligible dependents (Single Coverage).

*2 I need Health Dental for myself only, as my spouse/partner and/or children have coverage as noted below (Single Coverage with Forfeiture).

3. I need Health Dental for myself and my family (Family Coverage).

*4. I need Health Dental for myself and my family; and my spouse/partner and/or children also have coverage as noted below (Coordination of Benefits).

*5. I do not need Health Dental as I am covered through my spouse's/partner's plan as noted below (Forfeiture of Coverage).

*Does your spouse/partner have coverage elsewhere? Yes No → if "yes", you must complete the following information:

My spouse and children have coverage through:
*NAME OF INSURANCE CARRIER:

If you choose Options *2, *4 and *5 you must provide the above information about your spouse's/partner's coverage.

I understand that I can join the Health/Dental plan with Equitable Life® if I apply within 31 days of the termination of my spouse's/partner's coverage with his/her Employer. If I apply more than 31 days after the termination of my spouse's/partner's coverage, evidence of insurability will be required, and Dental coverage will be restricted. If I and/or my dependents have no current Group coverage, I understand I/we can apply in the future only with satisfactory evidence of insurability, and coverage may be restricted or denied.

Section C

PLEASE PROVIDE SPOUSE/PARTNER/CHILDREN DETAILS

This information is required if your Group Plan includes Dependent Life and/or if you are applying for Family Health and/or Dental Coverage

FULL NAME OF SPOUSE OR PARTNER (COMMON-LAW)		<input type="checkbox"/> MALE	DATE OF BIRTH	
FIRST	MIDDLE	LAST	month	day year
		<input type="checkbox"/> FEMALE		
1. FULL NAME OF CHILD		<input type="checkbox"/> MALE	DATE OF BIRTH	<input type="checkbox"/> DISABLED
FIRST	MIDDLE	LAST	month day year	† OR
		<input type="checkbox"/> FEMALE		<input type="checkbox"/> STUDENT
2. FULL NAME OF CHILD		<input type="checkbox"/> MALE	DATE OF BIRTH	<input type="checkbox"/> DISABLED
FIRST	MIDDLE	LAST	month day year	† OR
		<input type="checkbox"/> FEMALE		<input type="checkbox"/> STUDENT

† CHILDREN AGE 21 OR OLDER MUST BE REGISTERED AS A FULL-TIME STUDENT OR QUALIFY AS A DISABLED DEPENDENT.

If more than 2 dependent children, provide information for the additional children on the reverse side of this form.

The personal information willingly provided by me to my Plan Sponsor, the independent broker/sales advisor and/or Equitable Life, collected on this Application and held in their files, will be used by Equitable Life for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Group Insurance Policy and all benefits thereunder, and any supplementary documents. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by, Equitable Life, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians and dentists, and any other person or party whom I authorize.

If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that all claims made under the Group Insurance Policy are submitted through me as insured Plan Member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim.

I HEREBY CERTIFY THAT ALL OF THE INFORMATION PROVIDED ABOVE IS CURRENT AND ACCURATE. I AUTHORIZE THE USE OF MY S.I.N. FOR IDENTIFICATION PURPOSES AND DESIGNATE THE BENEFICIARY AS STATED ABOVE.

DATE	month	day	year	PLAN MEMBER'S SIGNATURE
------	-------	-----	------	-------------------------

THIS FORM WILL BE RETURNED IF NO DATE and SIGNATURE ARE PRESENT!

Section D

THIS SECTION TO BE COMPLETED BY THE PLAN SPONSOR/GROUP PLAN ADMINISTRATOR – Please make a copy for your records.

NAME OF GROUP POLICYHOLDER		NAME OF DIVISION/SUBSIDIARY OR AFFILIATE WHERE THE PLAN MEMBER WORKS		CLASS	BILLING SORT CODE (IF APPLICABLE)
DATE EMPLOYED FULL-TIME	OCCUPATION	H.C.S.A. STARTING BALANCE (if different from standard allocation)	EARNINGS	<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	STANDARD HOURS WORKED PER WEEK
month day year					

INSTRUCTIONS FOR COMPLETION OF NEW PLAN MEMBER GROUP INSURANCE APPLICATION (FORM NO. 191)

IMPORTANT: PLAN SPONSORS: PLEASE KEEP A COPY OF THIS APPLICATION FOR YOUR RECORDS.
 PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY.
 Incorrect or incomplete information will result in denial or improper payment of your claims.

For the purposes of this Group Insurance Policy,

“Spouse” means:

- a) the legally married husband or wife of the Plan Member, or
- b) a person of the same or opposite sex who resides with the Plan Member in a conjugal relationship and is publicly represented as the partner of the Plan Member.

“Dependent” means either a spouse as defined above, and/or your natural child, adopted child, stepchild or child of your spouse, under the age of 21, who normally resides with you.

Section A: To be Completed by the PLAN MEMBER. Please print.

Beneficiary Designations:

- Indicate the full name and relationship of the Beneficiary(ies) to you in the space provided.
- You have the right to change the Beneficiary at any time; however, where Quebec law applies, the beneficiary designation for your spouse must be designated as revocable to reserve this right.
- If more than one Beneficiary is appointed, proceeds will be payable in equal shares, unless you indicate otherwise.
- If the appointed Beneficiary is under the age of 18, a trustee of legal age must be appointed. If a Trustee is not appointed, proceeds will be paid to the Estate of the deceased. The full name of the trustee is required.

NOTE: You cannot appoint yourself as trustee or as beneficiary.

Section B: To be Completed by the PLAN MEMBER. Please print.

How to choose Health and/or Dental Benefits

- 1) If you require Single Health and/or Dental coverage because you have no eligible dependents, select Option 1, for SINGLE COVERAGE.
- 2) If your spouse and/or children are covered for Health and/or Dental benefits through another plan, but you want coverage for yourself only from Equitable Life®, select Option 2, for SINGLE COVERAGE WITH FORFEITURE.

Provide the name of your spouse’s/partner’s insurance carrier where indicated.

- 3) If you require coverage for yourself and your dependents, select Option 3, for FAMILY COVERAGE.
- 4) To Coordinate Benefits with your spouse’s/partner’s plan, select Option 4, for FAMILY COVERAGE WITH COORDINATION OF BENEFITS. You can submit claims under one plan and submit any remaining unpaid amounts to the other plan.

NOTE: CANADIAN LIFE & HEALTH INSURANCE ASSOCIATION REGULATIONS STIPULATE:

- A spouse/partner must submit claims to his/her own plan FIRST.
- Claims for insured children must first be submitted to the plan insuring the spouse/partner whose month of birth is the earliest in the calendar year. If both spouses/partners were born in the same MONTH, the earlier DAY would apply.

Provide the name of your spouse’s/partner’s insurance carrier where indicated.

- 5) If you and your dependents are covered under another plan, and you do not want Health and/or Dental coverage with Equitable Life at all, select Option 5, for FORFEITURE OF COVERAGE.

Provide the name of your spouse’s/partner’s insurance carrier where indicated.

Section C: To be Completed by the PLAN MEMBER. Please print. This information is required if your Group Plan includes Dependent Life and/or if you are applying for Family Health and/or Dental Coverage.

- Indicate the names and dates of birth of all dependents. Please confirm the accuracy of the birth dates, since errors will affect claims payments and dependent eligibility.
 - If you have more than 2 dependent children, provide additional information below.
- † Dependent children age 21 and older but under age 25 are eligible for coverage if registered as Full-time Students. You will be asked to provide proof of Full-time Student status.
- † Disabled Dependents age 21 and older may be eligible for coverage if certain conditions, as established by Equitable Life, are met. Application must be received by Equitable Life prior to the Disabled Dependent’s 21st Birthday.

Section D: To be Completed by the PLAN SPONSOR. Please print.
 For plans with Health Care Spending Accounts, indicate the Plan Member’s opening HCSA balance, if balance is different from your Group Policy’s standard allocation

CHILDREN DETAILS (cont’d)						
Section C (cont’d)	3. FULL NAME OF CHILD			<input type="checkbox"/> MALE	DATE OF BIRTH	<input type="checkbox"/> DISABLED
	FIRST	MIDDLE	LAST	<input type="checkbox"/> FEMALE	month day year	† OR <input type="checkbox"/> STUDENT
Section C (cont’d)	4. FULL NAME OF CHILD			<input type="checkbox"/> MALE	DATE OF BIRTH	<input type="checkbox"/> DISABLED
	FIRST	MIDDLE	LAST	<input type="checkbox"/> FEMALE	month day year	† OR <input type="checkbox"/> STUDENT

† CHILDREN AGE 21 OR OLDER MUST BE REGISTERED AS A FULL-TIME STUDENT OR QUALIFY AS A DISABLED DEPENDENT.