

ENROLMENT FORM (with Member Address)



SECTION A - MEMBER DETAILS

PLEASE PRINT CLEARLY

CONTRACT NUMBER: _____		CONTRACT HOLDER NAME: _____	
<input type="checkbox"/> New Member	<input type="checkbox"/> Re-Hire	Member ID No.:	<input type="checkbox"/> Social Insurance Number <input type="checkbox"/> Payroll <input type="checkbox"/> Certificate
Date of Hire/Re-Hire: _____ (yyyy-mm-dd)			
Effective Date of Coverage: _____ (yyyy-mm-dd)			
Location / Division No.: _____		Location / Division Name: _____	
Class / Plan: _____			
Member Name: _____			
First	Middle Initial	Last	
Member Address: _____			
City/Province		Postal Code	
Birth Date: _____ (yyyy-mm-dd)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Language: <input type="checkbox"/> English <input type="checkbox"/> French	
Member's Province of Residence: _____	Member's Province of Employment: _____		
Occupation: _____	Dependent Status: <input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Couple* <input type="checkbox"/> Single + 1 dependent* <input type="checkbox"/> Single + 2 or more dependents* * use only if applicable to your plan	
Salary: _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Civil Union		
Basis: <input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly Hrs/Wk. _____ <input type="checkbox"/> Other _____ (Please Specify)	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	

SECTION B - SPOUSE DETAILS

Name: _____	First	Last	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Date: _____ (yyyy-mm-dd)			
Is your spouse covered for Extended Health Care and/or Dental benefits by his/her employer's plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, please indicate spouse's coverage:			
Dental <input type="checkbox"/> Family <input type="checkbox"/> Single <input type="checkbox"/>			
Extended Health Care <input type="checkbox"/> Family <input type="checkbox"/> Single <input type="checkbox"/>	Name of Insurance Carrier: _____		

SECTION C - CHILDREN DETAILS

Names: _____ (First, last)	Birth Date: _____ (yyyy-mm-dd)	Gender: _____	* Student: _____ (yes/no)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

** Definition of a student is a child age 21 or over but under age 25 who is a full-time student attending an educational institution recognized by Canada Customs and Revenue Agency, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support. (For Quebec Members please check with your plan administrator for dependent student age maximum.)*

Note: Canadian Life and Health Insurance Association Guidelines (CLHIA) state:

1. A spouse must first claim from his/her own employer's plan.
2. Covered children must first claim from the plan covering the parent with the earlier date of birth in the year.

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.

SECTION D - REFUSAL OF BENEFITS

If you or your dependents are presently insured for Extended Health Care and/or Dental benefits under another group policy you may refuse to be insured for such benefit(s) under this contract by completing one or both of the following areas:

I refuse insurance for myself and my dependents under: Extended Health Care Dental

I refuse insurance for my dependents under: Extended Health Care Dental

SECTION E - REVOCABLE BENEFICIARY NOMINATION

NOTE: Any changes to the beneficiary must be initialed by the Member:

Beneficiary's Given Name, Family Name:

Relationship to Member

Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: Revocable

Please note that according to legal requirements, Sun Life Assurance Company of Canada cannot pay benefits to beneficiaries who are minors. A trustee for minor children must be designated, except in Quebec.

Beneficiary Trustee Nomination

Only complete Trustee Nomination section if nominating beneficiaries who are minors (other than Quebec)

Any payments becoming due during the minority of the minor(s) to be made to _____ as trustee, or failing such trustee to the duly appointed guardian of such minor child as trustee. Payment to said trustee shall discharge the company.

You must be authorized to disclose information about your spouse and dependents in order to enrol them in the Plan.

By enrolling in this Plan, I authorize the following:

- Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims,
- My plan sponsor to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required.

All information in this form is true and complete. A photocopy or electronic version of this authorization is as valid as the original.

Member Signature: _____

Date: _____