

<b>For office use only</b>
Morneau Shepell Authorized Signature
Comments

- Section **1** to be fully completed by Plan Sponsor/Employer in ink.
- Section **2 – 6** to be fully completed by Plan Member/Employee in ink.
- Return the ORIGINAL to the Plan Sponsor/Employer.
- Return a PHOTOCOPY to: (Mail) Morneau Shepell, 895 Don Mills Road, 4th Floor, Toronto ON M3C 1W3 or (Fax) 1-877-464-0109.

## 1 Plan Sponsor/Employer Information

Client name		Client/division code	Class
Cost centre (if applicable)	Employee hire/re-hire date D D / M M / Y Y Y Y	Employee effective date D D / M M / Y Y Y Y	Plan Member ID #
Insurance company name(s)		Policy/group contract numbers	Occupation
A)		Policy/group contract numbers	Waiting period
B)		Policy/group contract numbers	Annual salary
C)		Policy/group contract numbers	Hours worked/week
Employment status <input type="radio"/> Full-time <input type="radio"/> Part-time <input type="radio"/> Seasonal/contract <input type="radio"/> Other:			Hours worked/week

## 2 Plan Member/Employee Information

Last name		First name	Middle initial
Marital status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Civil union <input type="radio"/> Common-law*			* Date of cohabitation for Common-law D D / M M / Y Y Y Y
Mailing address			Gender <input type="radio"/> M <input type="radio"/> F
City	Province	Postal Code	Birth date D D / M M / Y Y Y Y

## 3 Plan Member/Employee Coverage and Family Information

Please list all of your eligible dependents, even if you select single coverage.

Do you have a spouse and/or dependent(s)? <input type="radio"/> Yes <input type="radio"/> No	Required health coverage <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	Required dental coverage <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family
Spouse's last name	Spouse's first name	Spouse's birth date D D / M M / Y Y Y Y
Does your spouse have benefits through an employer plan? <input type="radio"/> Yes <input type="radio"/> No		Spouse's gender <input type="radio"/> M <input type="radio"/> F
If yes, please indicate spouse's coverage: Health <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family		If yes, please provide carrier/policy #:
Dental <input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family		
Child's full name (last, first)	Birth date D D / M M / Y Y Y Y	Gender <input type="radio"/> M <input type="radio"/> F
		Student <input type="radio"/> Yes <input type="radio"/> No
		Disabled** <input type="radio"/> Yes <input type="radio"/> No
Child's full name (last, first)	Birth date D D / M M / Y Y Y Y	Gender <input type="radio"/> M <input type="radio"/> F
		Student <input type="radio"/> Yes <input type="radio"/> No
		Disabled** <input type="radio"/> Yes <input type="radio"/> No
Child's full name (last, first)	Birth date D D / M M / Y Y Y Y	Gender <input type="radio"/> M <input type="radio"/> F
		Student <input type="radio"/> Yes <input type="radio"/> No
		Disabled** <input type="radio"/> Yes <input type="radio"/> No

\*\* For disabled dependents, further information will be required.

Unless otherwise indicated in your employee benefit booklet, to be eligible for benefits coverage, your dependent children must be unmarried, under age 21, or under age 25 if they are a full-time student at a recognized school and dependent on you for financial support. **Disabled dependents may be eligible for benefits coverage if they became disabled before the limiting ages above, and are completely dependent on you for financial support.** Eligible dependents may vary depending on the benefit plan. Check with your Plan Sponsor/Employer for further information.

## 4 Waiver of Benefits

If you waive health and/or dental coverage and later lose coverage through another plan, you may apply for benefits under this plan within 31 days. Otherwise you and/or your dependents may be required to provide proof of insurability, and your benefits may be limited or denied under this plan.

If you or your dependents are presently covered for health and/or dental benefits under another benefits plan you may be able to waive coverage for such benefit(s) under this plan.

I waive coverage for myself and my dependents under:  Health  Dental

I waive coverage for my dependents under:  Health  Dental

## 5 Plan Member/Employee Beneficiary Information

If you designate a beneficiary who is:  
 (a) under 18 years of age, or  
 (b) mentally incapacitated  
 you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

If you are a Quebec resident and you designate your spouse as a beneficiary, you are not permitted to change that beneficiary unless you:

- (a) indicate that your designation of beneficiary is revocable, by checking the box on this form, or
- (b) your spouse agrees, in writing, to be removed as your beneficiary.

Original beneficiary information will be kept by your Plan Sponsor/Employer.

Name your beneficiary(ies)		
Beneficiary's last name	Beneficiary's first name	
Relationship to Plan Member	Percent allocated %	
Beneficiary's last name	Beneficiary's first name	
Relationship to Plan Member	Percent allocated %	
Beneficiary's last name	Beneficiary's first name	
Relationship to Plan Member	Percent allocated %	
	Total %	

I appoint \_\_\_\_\_ as Trustee to receive any amount designated to a beneficiary who is under the age of 18 or mentally incapacitated.

### For Quebec Residents Only

If you have designated your spouse as beneficiary, the designation will be irrevocable, unless you indicate that you wish it to be revocable below.

I wish to make my designation:  Revocable  Irrevocable

## 6 Plan Member/Employee Declaration

I consent to the collection, use, and exchange of my personal information by my Plan Sponsor/Employer or the administrator, an insurance company, and/or others who require information to administer my group benefits.

I authorize these parties to obtain and exchange between them, any information about me, my spouse, and my dependent children to determine benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependent children over the age of majority, to share information as it relates to the plan.

In the case of death, I expressly authorize my employer, the policyholder, the beneficiary, heir or liquidator of my estate to provide the Insurance companies, when required by the latter, with all the information and authorizations permitting the assessment of the claim and the collection of evidence.

I hereby apply for group benefits under my Plan Sponsor's/Employer's plan and authorize any required deductions.

I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my Plan Sponsor/Employer.

Plan Member/Employee signature

Date signed