RRC POLYTECH

retiree benefits
a choice for you

RETIREE GROUP BENEFITS APPLICATION

canada life

Coverage Policy No. 160978 - Ambulance/Hospital, Extended Health, Dental
Billing Policy No. 181928 - Premium Deductions

Return completed form no later than 2 weeks prior to retirement date.

RETIREE INFORMATION

Surname:	Given Name and Middle Initial(s):	Birth Date (*month/day/year*):	Gender: ☐ *Male* ☐ *Female* ☐ *Other* ☐ *Undisclosed*
Address:	City:	Retirement Date (last day of employment) (*month/day/year*):	ID #
Province: / Postal Code:	Phone Number: ( )	E-mail Address:	
Name of your Pay & Benefits Specialist *(if unsure, please contact your People Services department)*:			
Have you been covered under a Group Health Plan for a minimum of one year prior to date of retirement: ☐ *Yes* ☐ *No*			

DEPENDENT INFORMATION (IF APPLICABLE)

SPOUSE

Surname (if different from Employee Surname):	Given Name and Middle Initial(s):	Birth Date (*month/day/year*):	Gender: ☐ *Male* ☐ *Female* ☐ *Other* ☐ *Undisclosed*
☐ *Legally Married* ☐ *Common Law*	If common law, please provide commencement date of cohabitation (*month/day/year*):		

UNMARRIED DEPENDENT CHILDREN (Please use back of this page if additional space required.)

Surname (if different from Employee Surname)	Given Name and Middle Initial(s)	Gender				Birth Date (*month/day/year*)	Full-time Student		Disabled prior age 22	
		Male	Female	Other	Undisclosed		*Yes*	*No*	*Yes*	*No*
		☐	☐	☐	☐		☐	☐	■	■
		☐	☐	☐	☐		■	■	■	■
		☐	☐	☐	■		■	■	■	■

GROUP BENEFITS COVERAGE (Coverage and Monthly Premium Rates subject to change)

Benefits Coverage Section	**Select only one**	**Retirees must enroll according to their true family status.**		
		Single	***Couple***	***Family***
Decline all group benefits coverage offered	☐			
Option 1: Ambulance/Hospital	☐	☐ $27.15	☐ $52.75	☐ $55.03
Option 2: Ambulance/Hospital & Extended Health	☐	☐ $82.34	☐ $149.54	☐ $151.16
Option 3: Ambulance/Hospital & Extended Health & Basic Dental	☐	☐ $122.27	☐ $229.17	☐ $243.01
Option 4: Enhanced Coverage	☐	☐ $207.91	☐ $390.14	☐ $417.08

Retirees may reduce coverage (i.e. switch to a lower option) at any time, but will not be permitted to rejoin after opting out or to upgrade their option. If coverage is declined due to spousal coverage, retirees will be permitted to join when the spousal coverage terminates.

DECLINE (I.E. WAIVE) COVERAGE DUE TO DUPLICATE SPOUSAL GROUP BENEFIT COVERAGE (IF APPLICABLE)

Decline all group benefits coverage offered due to duplicate coverage through spouse's group benefits plan:	☐
Spousal insurer's name:	Plan number:

If you lose spousal coverage, you must apply for coverage within 60 days of loss of such coverage.

See reverse side →

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MONTHLY PREMIUMS

Monthly premiums will be withdrawn by Canada Life's Benefits Administration Solutions Team by Pre-Authorized Debit (PAD). Please complete the enclosed **Canada Life Personal Pre-Authorized Debit (PAD) Agreement - Bank Account Change Form**, attach a void cheque or direct deposit information, and **sign with an ink signature**.

AUTHORIZATION

I hereby apply for coverage under the Voluntary Retiree Group Benefits Plan as indicated above. I authorize HUB International and/or Canada Life:

- To automatically debit my bank account for the **monthly premium** as indicated above;
- To exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

Premium rates are reviewed annually and are subject to change. You will be notified in advance of any changes. I understand that if there are insufficient funds in the account to cover the monthly withdrawal, coverage will cease at the end of the month in which the last successful premium was received. Reinstatement may require a fee and/or medical evidence of good health.

I agree that a photocopy or electronic copy of this application is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Retiree Signature: _____Date *(month/day/year)*:_____

Please submit completed your Retiree Group Benefits Application form, Canada Life Personal Pre-Authorized Debit (PAD) Agreement - Bank Account Change Form (signed in ink) and include a copy of a void cheque or direct deposit form from your financial institution to:

E-mail: RRCretiree@hubinternational.com

Or

Mail:
HUB International
Attn: RRC Polytech Retiree Benefits
5th flr – 1661 Portage Ave.
Winnipeg, MB, R3J 3T7

For any questions, please contact HUB International at rrcretiree@hubinternational.com or toll free at 1-844-984-9456.

OFFICE USE ONLY:

Employee Number:	Retirement Date (*month/day/year*):	Entered on GroupNet by:	Division:	Benefit Class:
Retiree Coverage Effective Date (*month/day/year*):			Date Entered (*month/day/year*):	