MAXIMUM Benefit®

JG10

ENROLMENT APPLICATION

For office use only

Effective Date	Certificate #

To be Completed by Employer (Please print clearly in INK)

1

Firm/Company Name				Firm/Division #	
Division Name				Class	
Date of Full Time Employment (YYYY/MM/DD)			Employee Occupation		
Regular Earnings $	Frequency	☐ Annually ☐ Bi-Weekly	☐ Weekly ☐ Semi-Monthly	☐ Monthly ☐ Hourly	If hourly, # hours/week
Authorized Signature				Date (YYYY/MM/DD)	

Employee Information (To be completed by the employee – please print clearly in INK)

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Employee Name (Last)	(First)	(Initial)	
Address (Number, Street, Apt. Number)			
City	Province	Postal Code	
Province of Employment (if different)	Gender ☐ Male ☐ Female	Date of Birth (YYYY/MM/DD)	
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-Law: Date Started Living Together (YYYY/MM/DD)		Language of Preference ☐ English ☐ French	

Authorization for Direct Deposit

☐ I authorize Maximum Benefit to deposit my benefits payments into my account. I have attached a sample cheque, marked "VOID", to provide the banking details necessary for direct deposit, or a statement / letter from my financial institution showing its name, number, and my account number.

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PLEASE ATTACH A SAMPLE CHEQUE, MARKED "VOID"

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4 Dependent Information

List your spouse and children below (please print clearly in INK)

***MANDATORY WHEN DEPENDENT LIFE, EXTENDED HEALTH CARE OR DENTAL CARE BENEFITS ARE INCLUDED UNDER YOUR PLAN.**

Dependent's Name (Last, First) Include last name if different from your last name	Date of birth (YYYY/MM/DD)	Gender	Relationship to Employee*
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

Coverage under your Provincial Health plan is necessary in order for you and your dependents to be eligible for Extended Health coverage.

***If an over age dependent is disabled, please complete the *Request for Over Age Disabled Dependent Coverage* form. If a dependent is an over age dependent, please complete the *Request for Over Age Dependent Coverage* form. Please see your Plan Administrator for details.**

5 Waiver of Coverage Requested

You may waive Extended Health Care and Dental Care Benefits for yourself and your dependent(s) ONLY if you are covered for similar benefits under your spouse's plan. You may apply at a later date for benefits you have waived but certain restrictions may apply. *Please see your Plan Administrator for details.*

I waive coverage for:

Myself and my dependents under ☐ Extended Health Care ☐ Dental Care

My dependents only under ☐ Extended Health Care ☐ Dental Care

Spouse's Insurer's Name _____ Plan Number _____

6 Spousal Information for Co-ordination of Benefits

Spouse's Gender ☐ Male ☐ Female	**Spouse's Date of Birth** Date (YYYY/MM/DD)	
Spousal Health Coverage Does your spouse have health care coverage under his/her own plan? ☐ Yes: Name of Other Insurer _____ ☐ No		**Spousal Dental Coverage** Does your spouse have dental care coverage under his/her own plan? ☐ Yes: Name of Other Insurer _____ ☐ No
Spouse's Plan Covers: ☐ Your Spouse Only ☐ Your Spouse & Children Only ☐ Your Spouse & Yourself Only ☐ Your Spouse, Yourself & Your Children		**Spouse's Plan Covers:** ☐ Your Spouse Only ☐ Your Spouse & Children Only ☐ Your Spouse & Yourself Only ☐ Your Spouse, Yourself & Your Children

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Beneficiary Designation – Please print clearly in INK (crossed out or revised information must be initialled by the employee)

I hereby name the following beneficiary of any Life Insurance benefits payable as a result of my participation in this plan.

Last Name	First Name and Initial	% of Benefit	Relationship to Employee	Date of Birth (YYYY/MM/DD)

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Divided: ☐ As per percentages above (must total 100%) ☐ In equal shares to survivor(s)

When Quebec law applies, a spouse beneficiary is irrevocable (an irrevocable beneficiary must consent to any change) unless you make the designation revocable by checking here: ☐ **Revocable**, I may change this designation at any time

Trustee/Administrator Designation

If the beneficiary is under the age of majority, I appoint the trustee/administrator named below to receive any amount payable to a minor beneficiary under this policy. The trustee/administrator shall discharge the Insurer for the amount paid. I authorize the trustee/administrator to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Full Name **Relationship to Employee**

If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator.

For Quebec Only: The appointment will be interpreted in accordance with provisions governing the administration of property of others, under Quebec Civil Code.

Employee Signature (Please sign and date here)

Declaration and Authorization for the Collection and Communication of Personal Information

I hereby apply for Group Insurance for which I am, or may become, eligible under this plan and authorize any required payroll deductions for administration of my benefits. All the information I have provided on the form is accurate and complete, to the best of my knowledge, and I certify that I have no other coverage under the Maximum Benefit Plan and have not applied for any. I understand that I must be covered under my Provincial Health plan in order to be eligible for Extended Health coverage. I acknowledge that no benefits will be payable until the insurer approves this application.

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I authorize Maximum Benefit to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.maximumbenefit.ca or from the administrator of my benefit program.

A photocopy or electronic version of this **Declaration and Authorization** is as valid as the original.

A photocopy or electronic version of this form is **not valid** for recording beneficiary designations.

Signature of Employee _____ Date _____