GROUP ENROLMENT FORM

Reset Form

Throughout this form "Empire Life" means The Empire Life Insurance Company.

	Group number	Division	Certificate/payroll number
Employee first name	Last name		Date of birth (dd/mmm/yy)

1. EMPLOYMENT INFORMATION (TO BE COMPLETED BY THE PLAN ADMINISTRATOR)

Name of Employer/Division		Departmental code (max 5 numbers)	Occupation
Date of hire (dd/mmm/yy)	Number of hours/week	Effective date of coverage (dd/mmm/yy)	Class

Income details	**Amount**	**Indicate if salary amount is hourly, weekly, bi-weekly or annual**
Rate of pay		◯ Hourly _____ # of hours per week
Salary		◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Annual ◯ Other _____
Bonus		◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Annual ◯ Other _____
Commission		◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Annual ◯ Other _____

Signature of Employer X	**Date signed (dd/mmm/yy)**

2. EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

Empire Life may use your email address and/or phone number to contact you for administrative purposes.

◯ Male ◯ Female	Province of residence	Language preference ◯ English ◯ French	Marital status ◯ married ◯ single ◯ common-law
Email address		Phone number	Do you have a provincial health card? (e.g. OHIP, MSP) ◯ yes ◯ no

Claim payments

◯ **Deposit my Health, Dental and HCSA claim payments electronically to my bank account. (ATTACH A PERSONALIZED VOID CHEQUE).**

Spouse/Child Information – Please list all children. If more space is required, attach a separate sheet.

First name	Last name	Relationship (spouse, child)	Date of birth (dd/mmm/yy)	Gender (M/F)	Infirm dependant age 22 or older*	Full-time student age 22 or older**	Dependant has provincial health card?
					◯ yes	◯ yes	◯ yes
					◯ yes	◯ yes	◯ yes
					◯ yes	◯ yes	◯ yes
					◯ yes	◯ yes	◯ yes
					◯ yes	◯ yes	◯ yes

*Complete Overage Infirm Form and submit with Group Enrolment Form.
**Complete full-time student Information below – if more than one student, attach a separate sheet.

First name	Last name	Term start date (dd/mmm/yy)	Term end date (dd/mmm/yy)
Post-secondary school name		If outside Canada or US, provide country name and departure date (dd/mmm/yy)	

Empire Life

3. WAIVER/NOTICE FOR COORDINATION OF BENEFITS

Understanding your choice

- I acknowledge that I have been offered the benefits of my Employer's Group Insurance Plan with The Empire Life Insurance Company and benefits provided by this Plan have been fully explained to me.
- I am forfeiting (as indicated below) all my rights and privileges in respect to such benefits.
- I understand that if I apply for refused/waived coverage in the future, I may be required to provide evidence of insurability at my own expense.
- If waiver is not selected, family coverage will be applied.

Do you or any other member of your family have extended health or dental benefits with another plan? ◯ **yes** ◯ **no**
If yes, specify if coverage is: ◯ single coverage ◯ family coverage

Name of insurer

Waiver of extended health and/or dental coverage (spousal opt out) OR co-ordination of benefits:

I, and/or my dependants, have coverage with my spouse's Group Insurance Plan and I wish to:

◯ Waive the coverage for myself and my dependants (no extended health or dental with Empire Life)
◯ Waive the coverage for my dependants only (single extended health or dental with Empire Life)
◯ Co-ordinate Benefits (coverage with spouse's carrier **and** Empire Life)

Apply my selection to: ◯ **Extended health** ◯ **Dental** ◯ **Both** (If not specified we will apply to both health and dental coverage.)

Total Refusal of ALL Coverage

◯ **I waive all coverage for me and my dependants (non-mandatory plans only – see your Plan Administrator for details.)**

4. BENEFICIARY DESIGNATION (to be used only for benefits payable upon death of Insured Employee)

Minors: Death benefits will not be paid directly to a minor beneficiary. Outside Quebec, you should name a trustee for a minor beneficiary and any death benefits due to the beneficiary, while a minor, will be paid to the trustee on their behalf. In Quebec, death benefits due to a beneficiary, while a minor, will be paid to the their parent(s) or legal guardian unless you have established a formal trust. After the beneficiary reaches the age of majority, any death benefits due to the beneficiary will be paid directly to the beneficiary unless you have established a formal trust and such trust is still in effect at the time the death benefit is due.

Primary Designations: If a beneficiary is not named, the death benefit will be paid to the Estate of the Employee. Percentages for all beneficiaries must total 100%. If you name more than one beneficiary and do not indicate a share percentage, the death benefits will be divided equally among all surviving beneficiaries.

Irrevocable/Revocable Designations: A minor should not be designated as an irrevocable beneficiary. A minor irrevocable beneficiary cannot consent to a change of beneficiary until the minor reaches the age of majority and a parent or guardian may not sign on behalf of a minor child for this purpose. All beneficiaries are assumed revocable unless you check the irrevocable box except in Quebec. In Quebec, if a married or civil union spouse is named beneficiary, the designation is irrevocable unless otherwise indicated. Once an irrevocable primary beneficiary has been named, his/her written consent will be required for certain transactions.

Beneficiary(ies)

First name and middle initial		Last name	Relationship
◯ Revocable ◯ Irrevocable	Share (%)	Date of birth (if minor) (dd/mmm/yy)	Trustee name
First name and middle initial		Last name	Relationship
◯ Revocable ◯ Irrevocable	Share (%)	Date of birth (if minor) (dd/mmm/yy)	Trustee name
First name and middle initial		Last name	Relationship
◯ Revocable ◯ Irrevocable	Share (%)	Date of birth (if minor) (dd/mmm/yy)	Trustee name

5. DECLARATION AND AUTHORIZATION

Collection, Use and Access to My Personal Information

I am applying for group benefits coverage with The Empire Life Insurance Company ("Empire Life") and understand that Empire Life needs personal information about me, my spouse and my children (collectively "Dependants"), if applicable, relevant to this application and/or the administration of the group benefits plan ("Personal Information").

If I am applying for coverage for my Dependants:

- I confirm that I am authorized by my Dependants to disclose and receive their Personal Information, to act on behalf of my Dependants and to consent to this authorization on their behalf in relation to their Personal Information;
- I understand that the group benefits coverage is provided through me as the employee plan member and that Empire Life may exchange Personal Information with me and/or my Dependants.

Collection:

I authorize Empire Life and my employer to collect Personal Information from any person or organization that has information relevant to this application and/or the group benefits plan.

I authorize the following persons or organizations that have Personal Information to disclose such information to Empire Life:

- my employer and the group plan administrator;
- my employer's insurance broker and/or advisor (to the extent permitted by my employer);
- my doctor and other health professionals and practitioners (e.g. pharmacists, dentists);
- hospitals, clinics, social service agencies and other similar agencies that have provided services to me;
- professional regulatory bodies (e.g. College of Pharmacists);
- investigative and governmental agencies (e.g. Canada Revenue Agency);
- industry drug pooling entity (e.g. Canadian Drug Insurance Pooling Corporation);
- other insurance companies with which I have or have had coverage; and
- third party service providers that provide services related to the benefit plan (e.g. payroll, enrolment, claims handling services, travel emergency assistance benefits providers, paramedical service providers).

I also authorize the collection of Personal Information by third party service providers for purposes of assessing and administrating claims made by me, my Dependants, or my beneficiary(ies).

Use:

I authorize Empire Life to keep the Personal Information on file and use it for the following purposes:

- to assess the application;
- to assess the risk on a continuing basis and consider whether to issue or renew a group policy of insurance under which I might be or become insured;
- to determine the premium payable for such insurance;
- to assess eligibility for coverage and the nature and amounts of such coverage;
- to administer the group benefits plan, including conducting audits and investigations;
- to provide benefits and assess any claim(s) made by me, my Dependants, or my beneficiary(ies); and
- to comply with applicable law

Access/Disclosure:

I understand that:

- the Personal Information will be kept on file by Empire Life;
- authorized Empire Life employees, representatives, its reinsurers and third party service providers will have access to this file, for the purposes listed above;
- Personal Information may be exchanged with the persons and organizations listed above if required for the purposes listed above. However, specific details relating to medical conditions will not be disclosed to my employer;
- in all cases, Empire Life restricts its collection, use, disclosure and retention of Personal Information to what is reasonably required for the purposes listed above;
- Empire Life may use third party service providers located inside or outside Canada to process and store the Personal Information; and
- I have the right to request access to the Personal Information in the file, as permitted or required by law, and, where appropriate, to have any inaccurate information corrected. I can access Empire Life's most recent Privacy Policy at www.empire.ca.

Other:

I understand that:

- the statements in this application form part of the application in consideration for the insurance applied for; and
- I also understand and agree that any material misrepresentation or non-disclosure of information on this declaration may render my coverage voidable.

I certify that the information given in this and other supporting documents is true, full and complete.

I hereby apply for benefits for which I am or may become eligible, and authorize payroll deductions, if required.

A photocopy or electronic copy of this authorization will be as valid as the original.

Employee signature	**Date signed** (dd/mmm/yy)
X	