RBC Insurance

GROUP ENROLMENT FORM

Complete this form to enrol for Employee Benefits. Refer to the third page of this form for important instructions to accurately complete each section.	For RBCI Head Office Use Only OCC Code: _____

EMPLOYER SECTION *(to be completed by an Authorized Plan Administrator)*

☐ New Applicant ☐ Reinstatement	Name of Employer	RBCI Policy No.	Billing Division No.	Plan Member ID No. (if reinstated)	Alternate ID No. (if applicable)

Province of Employment	Employment Date (yyyy/mm/dd)	Class No.	Occupation	Earnings: ☐ Hr. ☐ Mth. $ _____ ☐ Wk. ☐ Yr.	No. of Hours Worked/Week

EMPLOYEE SECTION *(to be completed by Employee)*

Plan Member Last Name	First Name	Initial	Date of Birth (yyyy/mm/dd)	Gender: ☐ Male ☐ Female Language: ☐ English ☐ French

Home Mailing Address	City	Province	Postal Code	Number of Dependents

Marital Status: ☐ Single ☐ Married ☐ Common-law*

** I hereby certify that I have been living with my common-law partner since (yyyy/mm/dd)* _____

REFUSAL OR CO-ORDINATION OF BENEFITS SECTION
(to be completed by Employee only if Health and/or Dental is part of your Group Benefit Contract)

If you and/or your dependents are presently covered for Health and/or Dental Coverage under your spouse's Group Benefit Contract, you may refuse to be covered for such benefits under this Contract or Co-ordinate Benefits.

I understand the plan of group benefits offered to me, but **I wish** to:

Health Coverage: ☐ Decline coverage for myself and my dependents ☐ Decline coverage for my dependents ☐ Co-ordinate benefits

Dental Coverage: ☐ Decline coverage for myself and my dependents ☐ Decline coverage for my dependents ☐ Co-ordinate benefits

Name of Your Spouse's Group Insurer _____ Start Date of Coverage (yyyy/mm/dd) _____

To add these benefits at a later date, you must apply for coverage within 31 days of loss of spousal coverage. If you do not apply within 31 days, you and your dependents may be required to provide proof of insurability, and coverage may be restricted or denied.

DEPENDENT ENROLMENT INFORMATION SECTION
(to be completed by Employee only if Health and/or Dental is part of your Group Benefit Contract)

Health Coverage: ☐ Single ☐ Couple ☐ Family ☐ Waived Dental Coverage: ☐ Single ☐ Couple ☐ Family ☐ Waived

If there are more than four dependents, please attach a separate list.

Dep.	Last Name	First Name	Initial	Date of Birth (yyyy/mm/dd)	Gender (M/F)	Full-Time Student	Over-age Disabled Dependent
Spouse							
1st Child						☐	☐
2nd Child						☐	☐
3rd Child						☐	☐
4th Child						☐	☐

BENEFICIARY DESIGNATION SECTION
(to be completed by Employee for Life Insurance and Accidental Death Benefits)

Beneficiary's Last Name	First Name	Initial	Date of Birth (yyyy/mm/dd)	Gender (M/F)	Relationship	%

FOR RESIDENTS OF QUEBEC ONLY:
A spousal beneficiary designation is irrevocable unless otherwise specified. If spouse is the beneficiary, designation is:

☐ Revocable
☐ Irrevocable

If beneficiary is a minor or lacks legal capacity, an Appointment of Trustee is recommended in all provinces, except Quebec.

Trustee (Last Name, First Name) _____

Relationship to Employee _____

Is hereby appointed Trustee to receive any payment due to any designated beneficiary on record with RBC Life Insurance Company who is a minor on the date such payment falls due.

OPTIONAL LIFE SECTION
(to be completed by Employee only if Optional Life is part of your Group Benefit Contract)

Evidence of Insurability form is required when applying for this benefit; please attach it to this form.

Amount of Coverage Selected for: You: $ _____ Spouse: $ _____ Each Child: $ _____

Have you used any narcotic, tobacco product, marijuana or hashish, smoking cessation products, tobacco substitute such as betel nuts, betel leaves, supari, paan or gutka within the last twelve (12) months? ☐ Yes ☐ No

Has your spouse used any narcotic, tobacco product, marijuana or hashish, smoking cessation products, tobacco substitute such as betel nuts, betel leaves, supari, paan or gutka within the last twelve (12) months? ☐ Yes ☐ No

MAILING INSTRUCTIONS

A copy of the completed form should be mailed to the RBC Address that appears on your Group Billing Statement.

AUTHORIZATIONS AND DECLARATIONS
(to be signed by both an Authorized Plan Administrator and Employee)

By signing this enrolment form and providing my personal information to my employer, I confirm that the information is complete and accurate to the best of my knowledge. I authorize my employer to share my personal information and my spouse's and dependent's personal information with my employer's third-party administrator and with RBC Life Insurance Company and its service provider in order to administer the insurance coverage. I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes.

I hereby apply for group insurance coverage for which I am now or may later become eligible and authorize my employer to deduct the required contribution, if any, from my pay. I agree that any insurance issued as a result of this application shall take effect on the date I am actively employed on a full-time basis, otherwise on the date I return to full-time active employment, subject to approval by RBC Life Insurance Company and any waiting period pertinent to my employer's plan. RBC Life Insurance Company shall not be liable for any claim commencing prior to the effective date of insurance.

Plan Administrator Signature: _____ Date (yyyy/mm/dd): _____

Plan Member Signature: _____ Date (yyyy/mm/dd): _____

INSTRUCTIONS

Complete each section according to the instructions listed below and sign the bottom of the form when you are sure that the information is complete and accurate. Incorrect or incomplete enrolment information could result in denial or improper payment of your claims.

EMPLOYER SECTION

1. Mark the appropriate box to indicate if the employee is new or is applying to be reinstated.
2. Please record the Plan Member's ID No. *only* if you are applying to reinstate that member.
3. Please record the Alternate ID No. (9 characters) if you would like to uniquely identify a plan member (i.e. Cost Centre; Badge Number).
4. Please record the province of employment.
5. Please record the date when full-time or part-time employment commenced.
6. If your Group Benefit Contract is different for classes of employees (i.e. union/non union, management/staff), please indicate the classification the employee falls into.
7. Please record the employee's occupation.
8. Please record the employee's earnings (as per the definition of earnings in your Group Benefit Contract), payment period and number of hours worked each/every week.

EMPLOYEE SECTION

1. Print your name and full mailing address in the designated areas. Please record the first name by which you will refer to yourself when submitting claims as this name will also appear on your Group Benefit Card. (i.e. If Robert will be used when submitting a claim, do not use Bob when completing this form.)
2. Enter date of birth, then mark the appropriate box to indicate gender and language.
3. Please record number of dependents.
4. A marital status of common-law means that you have been living with your common-law partner for a continuous period of at least 12 months.

REFUSAL OR CO-ORDINATION OF BENEFITS SECTION

To be completed ONLY if Health and/or Dental Coverage is part of your Group Benefit Contract

1. If you are eligible for Health and/or Dental Coverage through your spouse's Group Benefit Contract, you can either refuse to be covered for such benefits under this Contract or request co-ordination of benefits by selecting the applicable box.
2. Please record your spouse's group insurer and the start date of that coverage.

DEPENDENT ENROLMENT INFORMATION SECTION

To be completed ONLY if Health and/or Dental Coverage is part of your Group Benefit Contract

1. For Health and/or Dental Coverage please indicate your family status by checking the appropriate box (Single, Couple, Family or Waived).
2. Print the names in full of each dependent eligible to be covered under your employer's Group Benefit Contracts. Be sure to use the first name that will be used when submitting claims, as this name will also appear on your Group Benefit Card. (i.e. If Betty will be used when submitting claims, don't use Elizabeth when completing this form.)
3. Enter the full date of birth for each dependent. Please confirm the accuracy of these birth dates since they will affect claims payment and dependent eligibility.
4. Enter "M" (male) or "F" (female) to identify the gender of each dependent.
5. If your dependent is an over-age adult dependent (as defined in your Group Benefit Contract), please check the appropriate box (Full-time Student or Over-age Disabled Dependent).

BENEFICIARY DESIGNATION

1. For Quebec residents, if your spouse is your beneficiary, then you must designate your beneficiary as either "Revocable "or "Irrevocable." If you do not indicate"Revocable" it will be assumed (per provincial legislation) that your spouse is your "Irrevocable" beneficiary. **Revocable**: you may change your beneficiary (per the Group Benefit Contract) without the written consent of the current beneficiary. **Irrevocable**: you may not change your beneficiary (per the Group Benefit Contract) without the written consent of the current beneficiary.
2. Please ensure that you have indicated your beneficiary's relationship to you and the percentage. For multiple beneficiaries, the percentages must total 100%.

OPTIONAL LIFE SECTION

To be completed ONLY if Optional Life is part of your Group Benefit Contract

1. An Employee must be insured for Group Basic Life Insurance in order for the employee, spouse or his/her dependents to be insured for this benefit, and an Evidence of Insurability Form is required when applying for the Optional Life Benefit.

MAILING INSTRUCTION SECTION

1. The Plan Administer must maintain the original version of the Signed Group Enrolment Form and send a copy to RBC Life Insurance Company.
2. To confirm the mailing address please call your RBC Customer Service Representative at 1-855-264-2174.