

**GROUP INSURANCE
ENROLMENT CARD**



Benefit plans administered by:

**D.A. TOWNLEY
& ASSOCIATES LTD.**

OFFICE USE _____

EMPLOYEE INFORMATION

EMPLOYEE SURNAME		FIRST NAME	INIT.
SOCIAL INSURANCE NO.		BIRTHDATE (Yr. Mo. Day)	
MARITAL STATUS	PROVINCE OF RESIDENCE	MALE/FEMALE	
REVOCABLE BENEFICIARY DESIGNATION NOTE: If beneficiary is an underage child, please name an adult "in Trust for" the child.			
SURNAME		FIRST NAME	RELATIONSHIP

DEPENDENT INFORMATION

FIRST NAME (If different from Applicant's)	SURNAME	RELATIONSHIP TO INSURED	BIRTHDATE YR. MO. DAY	STUDENT Y/N
01 Spouse* (if common-law see reverse)				
02 (oldest first)				
03				
04				
05				

CO-ORDINATION OF BENEFITS

ARE YOU COVERED BY ANOTHER PLAN FOR DENTAL? NO _____ YES _____ FOR EHB? NO _____ YES _____

IF YES, INS. CO./GROUP NO. _____ SPOUSE SIN or ID NUMBER _____

If you or your dependents do not require all benefits, you must complete the waiver in the reverse side of this card.

If adding children over the age of 19, indicate school they are attending full-time:

PHARMA CARE REGISTRATION No. _____

To Protect Your Privacy In order to verify your identity when you call the Administrator, please provide a personal fact or question along with the answer that only you would be able to answer. (i.e., your mother's maiden name, place of birth, etc.) Question: _____ Answer: _____

I authorize the use of my Social Insurance Number for identification purposes. I understand that D.A. Townley & Associates Ltd. collects personal information to assess eligibility for benefits; to determine and adjudicate benefits; to determine the cost and financially manage these benefits as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. This information may be released to the insurer(s) when necessary to provide benefits.

Employee's Signature _____

Date _____

EMPLOYER'S STATEMENT

NAME OF EMPLOYER:		AUTHORIZED SIGNATURE:			
EMPLOYEE'S DATE OF EMPLOYMENT	NEW OR REHIRED <input type="checkbox"/>	EMPLOYEE'S CLASS/ DIVISION	EMPLOYEE'S OCC.	EMPLOYEE'S EARNINGS <input type="checkbox"/> HOURLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	HOURS WORKED PER WEEK

Nov/06 10M

REFUSAL – WAIVER OF BENEFITS

I understand the Plan of Group Insurance offered to me. However, if permitted by the provisions of the Plan, I decline to participate in the following:

in the Dental Insurance in the Extended Health Insurance (may include Vision under some plans)

other (specify) _____

For myself and/or My dependents

REASON FOR REFUSAL

Comparable coverage is provided for me and/or my dependents under my Spouse's plan:

Name of Insurer _____ Group No. _____ Certificate No. _____

I agree that if at a later date I wish to participate in the insurance hereby refused, I must submit, at my own expense, evidence of insurability for myself and any dependents for whom application for coverage is made. However if I have refused Health/Dental Insurance because of other group coverage, such evidence of insurability will not be required provided the alternate coverage terminates and I apply for Health Insurance within 31 days of the termination date.

Date _____ Employee's Signature _____

DECLARATION OF COMMON-LAW DEPENDENTS

Common-Law Spouses and their children **may be** eligible with a minimum co-habitation period which is indicated in your group policy.

I hereby certify that I have been living with _____ since _____ and representing him/her as my Spouse. NOTE: Only the children of your Common-Law Spouse who are residing with you are eligible dependents under the Plan.

Date _____ Employee's Signature _____

If available under the provisions of the Plan, I wish to apply for: Optional Life Insurance in the amount of \$ _____
Spousal Optional Life Insurance \$ _____

Health Evidence forms must be submitted for the above Optional Benefits. Optional Life Insurance and Spousal Optional Life Insurance will not become effective until the insurance company approves the additional benefit applied for, based on the health evidence submitted.