



ENROLMENT APPLICATION

For office use only

Effective Date

Certificate #

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

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

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

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

PLEASE ATTACH A SAMPLE CHEQUE, MARKED "VOID"

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*
		<input type="radio"/> M <input type="radio"/> F	
		<input type="radio"/> M <input type="radio"/> F	
		<input type="radio"/> M <input type="radio"/> F	
		<input type="radio"/> M <input type="radio"/> 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.**

Waiver of Coverage

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 _____

Spousal Information for Coordination of Benefits (Do not complete if Waiver of Coverage is requested)

Spouse's Gender <input type="radio"/> Male <input type="radio"/> 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? <input type="radio"/> Yes: Name of Other Insurer _____ <input type="radio"/> No	Spousal Dental Coverage Does your spouse have dental care coverage under his/her own plan? <input type="radio"/> Yes: Name of Other Insurer _____ <input type="radio"/> No
Spouse's Plan Covers: <input type="radio"/> Your Spouse Only <input type="radio"/> Your Spouse & Yourself Only <input type="radio"/> Your Spouse & Children Only <input type="radio"/> Your Spouse, Yourself & Your Children	Spouse's Plan Covers: <input type="radio"/> Your Spouse Only <input type="radio"/> Your Spouse & Yourself Only <input type="radio"/> Your Spouse & Children Only <input type="radio"/> Your Spouse, Yourself & Your Children

Maximum benefit.

Primary Beneficiary Designation – Please print clearly in INK:

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

Divided: <input type="radio"/> In equal shares to survivor(s) (Do not need to enter % of benefit) <input type="radio"/> As per percentages below				
Last Name	First Name and Initial	% of Benefit (must total 100%)	Relationship to Employee	Date of Birth (YYYY/MM/DD)

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 (must be over the age of majority)

If the beneficiary is under the age of majority (not applicable for QC residents), 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.

Contingent Beneficiary Designation – OPTIONAL (Cannot be the same beneficiary as listed under Primary Beneficiary)

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Divided: In equal shares to survivor(s) (Do not need to enter % of benefit) As per percentages below

Last Name	First Name and Initial	% of Benefit (must total 100%)	Relationship to Employee	Date of Birth (YYYY/MM/DD)

Trustee/Administrator Designation (must be over the age of majority)

If the beneficiary is under the age of majority (not applicable for QC residents), 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.

I authorize Maximum Benefit and its insurers 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.

Employee's Name (please print) _____

Employee's Signature _____ Date _____

The original of this form must be submitted. Photocopies are not accepted. Please mail this completed form to the address below.