Maximum benefit.

JG10

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	◯ 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)

Employee Name (Last)		(First)	(Initial)
Address (Number, Street, Apt. Number)			
City		Province	Postal Code
Employee Email Address			
Province of Employment (if different)	Gender ◯ Female ◯ Male ◯ Other Expression ◯ Undisclosed		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.

PLEASE ATTACH A SAMPLE CHEQUE, MARKED "VOID"

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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 Female/Male Other Expression/Undisclosed	Relationship to Employee*

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

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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: ◯ **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)**

Where 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.

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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)

Where 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.

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 Maximum Benefit 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. I authorize such collection and disclosure to be conducted by any means necessary, including electronic communication methods such as email. 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.

MAXIMUM BENEFIT NATIONAL SERVICE CENTRE
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