Benefits Coordinators BCI inc.

Application for Group Insurance

☐ New employee
☐ Reinstatement

Effective date of Insurance	YY / MM / DD

I - ADMINISTRATIVE INFORMATION (PLEASE PRINT)

Policyholder/ Employer	Policy No.	Division No.
Able Innovations Inc.	355123	

Participant's Last Name	First Name(s) (abbreviate if necessary)	Initials	Social Insurance Number (Optional)	Identification No. (Certificate #)

Participant Address	# and Street	City	Province	Postal Code

Date of Birth	Sex	Marital Status			If common-law, since :	Language	
YY / MM / DD	☐ Male ☐ Female	☐ Single ☐ widowed	☐ Married ☐ Divorced	☐ Separated ☐ Common-law	YY / MM	☐ English	☐ French

II - COMPLETE TO ENROLL NEW EMPLOYEE

Permanent full time since		Participant's occupation	Class	Salary (Yearly)	If Hourly	
	YY / MM / DD			$	____/ hour a week at ____$/ hour	☐ Owner / Shareholder ☐ Other

III - COMPLETE TO REINSTATE EMPLOYEE

Date previous employment ended : YY / MM / DD Date reinstated : YY / MM / DD

IV -DEPENDENT COVERAGE

A DEPENDENT IS YOUR SPOUSE AND/OR ANY DEPENDENT CHILDREN. If your child is 21 or older, he/she must proove his/her eligibility. Please refer to your plan administrator for clarifications. If you have any questions regarding the eligibility of dependents, please contact your Employer.

Do you have eligible dependents? ☐ Yes ☐ No

LIST OF COVERED ELIGIBLE DEPENDENTS

	Last Name(s)	First name (s)	Sex M/F	Dependent children of Spouse	Dependent children of Participant	Date of birth Y M D	Full-time student	Disabled
Spouse						YY / MM / DD		
Child						YY / MM / DD		
Child						YY / MM / DD		
Child						YY / MM / DD		
Child						YY / MM / DD		
Child						YY / MM / DD		

V - COORDINATION AND WAIVER OF BENEFITS (Complete only if you and/or dependant are covered for similar benefits under another plan)

WAIVER OF BENEFITS (Check the appropriate boxes to decline coverage for yourself and/or your family members)

Waiver of member's coverage
☐ Health insurance
☐ Dental care insurance

Waiver of dependent's coverage
☐ Health insurance
☐ Dental care insurance

Spouse's name _____ Spouse's Employer _____

Insurance company through which spouse is insured _____ Policy number _____

COORDINATION OF BENEFITS (Check the appropriate boxes)

Coverage under your spouse's plan
Health : ☐ Individual ☐ Family ☐ Waived (no coverage)
Dental : ☐ Individual ☐ Family ☐ Waived (no coverage)

All the information on this page has been verified by an authorized representative named by the policyholder.
Must be signed with a blue pen only.

Employer : _____ Title : _____ Date : _____/_____/_____

see reverse ▶

VI - BENEFICIARY DESIGNATION (If no beneficiary is designated by the member, then the benefit is payable to the estate)

Last Name	First Name(s)	Relationship to Participant

VII - DECLARATION APPOINTING TRUSTEE (COMPLETE IF BENEFICIARY IS UNDER LEGAL AGE)

I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under legal age and declare that the receipt of such Trustee shall be a valid discharge to the Insurer for the amount so paid. I also hereby authorize such Trustee at his/her discretion to apply on behalf of such beneficiary the whole or any portion of such amount and the income derived therefrom for the care, maintenance, education, advancement in life or other benefit of such beneficiary.

Signature of Participant X _____

VIII - QUEBEC PARTICIPANTS (TO BE COMPLETED ONLY IF BENEFICIARY IS YOUR SPOUSE)

In Québec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If you name your spouse, the Insurers recommend that you make a revocable designation in order to facilitate any future request for a change of beneficiary.

An irrevocable designation cannot be changed unless the beneficiary aged 18 or over signs a waiver of rights. Please sign in the box corresponding to your choice ONLY IF you designate your SPOUSE as beneficiary.

The designation is revocable

Signature of Participant

OR

The designation is irrevocable

Signature of Participant

IX - OPTIONAL BENEFITS (LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT - A.D. & D.)

If you wish to have optional benefits and your contract includes such possibilities, please refer to your Employer/ Plan Administrator.

X - AUTHORIZATION

I authorize my employer, the policyholder, the Insurers, and their respective representatives and mandataries to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any, under this Program, within the limits of the law regar-ding the protection of personal information.

I hereby accept the conditions of this policy and I authorize the necessary contributions to be made through salary deductions. I agree to the use of a Participant's number under this plan and as my identifier for my employer's Group Insurance Program.

In case of death, I expressly authorize the policyholder, the employer, the beneficiary, heir or liquidator of my estate to provide the Insurers, when required, with all the information and authorizations permitting the study of the claim and the obtaining of evidence.

This consent is valid for the purpose of this Program, or any modification, extension or reinstatement of thereof.

A photocopy of this consent is as valid as the original if it used for information sharing purposes.

I may apply at a later date, for benefits I have previously waived, without penalties if done within 30 days of the date I have lost such benefits on my spouse's plan. I also understand that certain conditions may apply.

Signature of Participant X _____ Date: YY / MM / DD