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EMPLOYEE APPLICATION FOR GROUP COVERAGE

EMPLOYER SECTION: This section is to be completed by the Plan Administrator.

Employer: _____

Policy No.: _____ Division No.: _____ Benefit Class: _____ ID #: _____

Date of permanent full-time employment: (mm/dd/yyyy) _____ Date Eligible: (mm/dd/yyyy) _____

Occupation: _____

Earnings: _____ per ❑ year ❑ month ❑ week ❑ hour No. of hours per week: _____

Employee: Residence Province: _____ Employment Province: _____

EMPLOYEE SECTION: This section is to be completed by the Employee. PLEASE PRINT CLEARLY IN INK.

Employee Name: _____
last name first name middle initial

Gender: ❑ male ❑ female Date of birth: Month _____ Day ___ Year _____ SIN #: _____

Mailing Address: _____
(street no.) street name) (city) (province) postal code)

Do you have a spouse/common law spouse? ❑ Yes ❑ No other dependents - children/students/disabled persons? ❑ Yes ❑ No

How many dependents in total, including spouse/common law spouse? _____

REFUSAL OF BENEFITS: Health, Dental and/or Vision coverage may only be removed if you have DUPLICATE group benefits through your spouse's employer.

I understand the plan of group benefits offered to me, but I decline to participate in:

Healthcare for ❑ myself and my dependents ❑ my dependents only

Dentalcare for ❑ myself and my dependents ❑ my dependents only

Spousal insurer's name: _____ Policy No.: _____

If you lose spousal coverage you must apply for coverage within 31 days of loss of such coverage. If you do not apply within 31 days you may be required to provide acceptable proof of your insurability to be covered. If you are approved, dental benefits, if applicable, may be restricted.

Please see your plan administrator for details.

DEPENDENT INFORMATION: Complete this section **if you have NOT REFUSED dependent coverage**. PLEASE PRINT CLEARLY IN INK.

If there is not enough room to list all your dependents, please attach a separate list.

Spouse/Common Law Spouse Information

_____
last name first name middle initial

Date of birth (mm/dd/yyyy) _____

Gender ❑ Male ❑ Female

What group benefits coverage does your spouse/common law Spouse have through an employer?

	Single	Family	Waived	None
HEALTHCARE	❑	❑	❑	❑
DENTALCARE	❑	❑	❑	❑

FOR COORDINATION OF BENEFITS: Spousal Insurance Company Name: _____
Policy No.: _____

To be completed by the Plan Administrator.
Policy No.: _____ **Div. No.:** _____ **Employee Name:** _____

Dependent Information (Continued):

last name	first name	middle initial	Date of birth (mm/dd/yyyy)	Gender		Full time student		Disabled dependent	
				Male	Female	Yes	No	Yes	No
				❑	❑	❑	❑	❑	❑
				Male	Female	Yes	No	Yes	No
				❑	❑	❑	❑	❑	❑
				Male	Female	Yes	No	Yes	No
				❑	❑	❑	❑	❑	❑
				Male	Female	Yes	No	Yes	No
				❑	❑	❑	❑	❑	❑

Over Age Student Information (for full time students over age 21):

Name of Over Age Student	School Attended (University or College)	Enrolled From (mm/dd/yyyy)	Enrolled To (mm/dd/yyyy)

BENEFICIARY DESIGNATION: This section is to be completed by the employee to designate a beneficiary for your life benefits. The original copy of this form will be required for a life claim. **PLEASE PRINT CLEARLY IN INK AND INITIAL ANY SCRATCH OUTS OR WHITE-OUTS.**

Beneficiary's Name(s) * last name	first name	middle initial	DOB (mm/dd/yyyy)	Percent allocated	Relationship to Employee

*** Trustee Name:** _____ Relationship: _____
(Required if beneficiary is a minor under age 18)

You must make your beneficiary designation revocable or irrevocable by checking one of the circles below. You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary.

Note: Where Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable" below.

I hereby make the above beneficiary designation: ❑ **Revocable** ❑ **Irrevocable**

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee / administrator.

Authorizations & Declarations:

I designate the person(s) named above under Beneficiary Designation as my beneficiary. I certify that the information in this form is true and complete, to the best of my knowledge. If applying for benefits for my spouse/common law spouse and/or my dependents, I am authorized to release information concerning my spouse/common law spouse and my dependents for the purpose of determining their eligibility for benefits.
If my social insurance number is used as my certificate number, I authorize use for the identification and administration of my group benefits. I authorize Unistar Special Risks Inc. to make any and all inquiries, or to exchange information, relating to group benefits claims and administration on behalf of myself and my dependents.
For Quebec applicants: I request that this form be in English. Je demande que ce formulaire me soit remis en anglais.

_____ Employee Signature

_____ Date