

**Identification of the Participant**

Last Name		First Name		S.I.N. (OPTIONAL)	
Address				Work Tel.	
Town/City		Province	Postal Code		Home Tel.
Email		Date of Birth Y   M   D	Language Preference <input type="radio"/> English <input type="radio"/> French	Gender <input type="radio"/> M <input type="radio"/> F	Do you have a spouse (married, common-law or civil union spouse)? <input type="radio"/> Yes <input type="radio"/> No

**Coverage**

**Health Insurance**  Individual  Family  None. I am covered under my spouse's plan.

**Dental Care Insurance**  Individual  Family  None. I am covered under my spouse's plan.

**Optional Life Insurance (if applicable)**

	PARTICIPANT	SPOUSE				
Amount of Optional Life Insurance requested (1) (2)	\$ _____	\$ _____				
Identification of Spouse:	<table border="1"> <tr> <td>Last Name</td> <td>First Name</td> <td>Gender <input type="radio"/> M <input type="radio"/> F</td> <td>Date of Birth Y   M   D</td> </tr> </table>		Last Name	First Name	Gender <input type="radio"/> M <input type="radio"/> F	Date of Birth Y   M   D
Last Name	First Name	Gender <input type="radio"/> M <input type="radio"/> F	Date of Birth Y   M   D			
<b>Non-smoker's declaration</b>	<p>By checking the non-smoker declaration box below, you (and your spouse, if applicable) are declaring that the following statement is true and complete. You also acknowledge that if you make a false declaration, your coverage may be voided.</p> <p>"I understand that to be considered a non-smoker, I must not have smoked during the twelve (12) months prior to the application for insurance. I understand that the insurer may periodically require confirmation of non-smoker status; in such case I must be able to meet the requirements in force at that time and return confirmation within 30 days of the insurer's request, failing which I will no longer benefit from non-smoker status and the associated reduction in premiums, effective as of the date of the insurer's request."</p>					
PARTICIPANT: Non-smoker <input type="radio"/>	Signature of Participant	SPOUSE: Non-smoker <input type="radio"/> Signature of Spouse				

NOTE (1) Optional Life Insurance: Do not include the amount of Basic Life Insurance coverage.  
NOTE (2) Optional Life Insurance: This coverage may not be available under your group insurance plan. Please check with your plan administrator.

**Spouse and Dependent Children**

Spouse's last name: \_\_\_\_\_ First name: \_\_\_\_\_ Date of birth: Y | M | D Gender:  M  F

What type of Health Insurance coverage does your spouse have under another policy?  Individual  Family  None

What type of Dental Care Insurance coverage does your spouse have under another policy?  Individual  Family  None

First and last name of child	Gender	Date of birth	Does the child have a disability?	Is the child a full-time student?	Name of educational institution
	<input type="radio"/> M <input type="radio"/> F	Y   M   D	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	<input type="radio"/> M <input type="radio"/> F	Y   M   D	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	<input type="radio"/> M <input type="radio"/> F	Y   M   D	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	<input type="radio"/> M <input type="radio"/> F	Y   M   D	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	<input type="radio"/> M <input type="radio"/> F	Y   M   D	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
	<input type="radio"/> M <input type="radio"/> F	Y   M   D	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	

**Beneficiary**

OR  The amount insured will be payable to my estate

I wish to designate the following beneficiary(ies) in the event of my death:

Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This beneficiary designation is\*:  
 Revocable (beneficiary designation may be changed at any time)  
 Irrevocable (beneficiary designation can only be changed with the written consent of the designated beneficiary(ies))

\* In Quebec, when no beneficiary status is specified, designation of the legal spouse is irrevocable and designation of any other beneficiary is revocable.

If you designate more than one beneficiary, the insurance proceeds will be distributed evenly between them unless you specify the percentage of the insurance you wish to allocate to each beneficiary.

I hereby appoint (full name, relationship) \_\_\_\_\_ as Trustee to receive any amount payable to a minor beneficiary under this policy and declare the receipt by such Trustee shall discharge the Insurance Company for the amount so paid. And I do hereby authorize the Trustee, within his/her discretion, to expend all or any such amount and/or the income resulting from the proceeds for the maintenance or education of such minor. (You must appoint a trustee if your beneficiary is under age 18.)

PARTICIPANT TO COMPLETE

