Group Insurance Enrollment / Change Form

Please mail original completed form to Associum Benefits | One Concorde Gate, Suite 802 | Toronto | Ontario | M3C 3N6

ASSOCIUM Benefits

Type of Change: ☐ New Employee ☐ Reinstatement ☐ COB Change ☐ Add Dep(s) ☐ Termination ☐ Delete Dep(s) ☐ PPR (OHIP)

Part A – Employer Section

Effective Date of Change:

Name of Employer							
Occupation			Annual Earnings	Hrs / Week	Class Code	Certificate Number	
Date of Hire			Date of Rehire			I certify that the plan member listed below is actively at work at their usual place of employment in Canada. Actively at work means the plan member works a normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation	
Month	Day	Year	Month	Day	Year	X _____ Date: _____	
						Authorized Signature of Employer	
						Note: Please mail original completed form to ASSOCIUM Benefits	

Part B – Employee Section

Employee Last Name	First Name	Initial	
Address	City	Postal Code	Province of Residence

Gender	Date of Birth			Language Preference ☐ English ☐ French	Coverage for: ☐ Single ☐ Family
☐ Male ☐ Female	Month	Day	Year	Marital Status ☐ Single ☐Married ☐ Divorced ☐ Separated ☐ Common Law *	
				* Date of Cohabitation _____(Date is mandatory if Common Law)	

Dep. No.	List Dependants Last Name First Name	Sex M/F	Date of Birth Month	Day	Year	If child is over 21 years of age and attending school full-time, provide name of school. If child is handicapped, state nature of disability to apply for coverage beyond plan's age limits.
01	Spouse					
02	1st Child					
03	2nd Child					
04	3rd Child					
05	4th Child					

Coverage Applied for : ☐ Health ☐ Dental ☐ PPR (OHIP)

Do you have coverage under another Extended Health or Dental plan? (e.g. your spouse's group plan) If yes, please provide details elow:

Name of Insurance Company	Group Policy Number	ID Number	☐ Health ☐Dental

I will be co-ordinating benefit coverage with my spouse's plan for: ☐ Extended Health Care ☐ Dental Care

I elect to waive the benefits indicated below because comparable coverage is provided to me and/or my dependants under my Spouse's plan:

For myself and my dependants …… ☐ Extended Health Care ☐ Dental Care Is this your Spouse's plan? ☐ Yes ☐ No

For my dependants only …… ☐ Extended Health Care ☐ Dental Care

Beneficiary Designation

I revoke all prior beneficiary designations under this certificate. I hereby designate the following person(s) to receive all group life insurance benefits payable on my death. If more than 1 person is named, proceeds are to be shared equally, unless otherwise stated below.

Full Legal Name	Relationship	% Share

Contingent Beneficiary Designation

Full Legal Name	Relationship	% Share

Trustee Designation (complete if beneficiary is under age 18)

I appoint as revocable Trustee to receive any amount which may be due my beneficiary while such beneficiary is a minor:

X _____

Full Legal Name *Date*

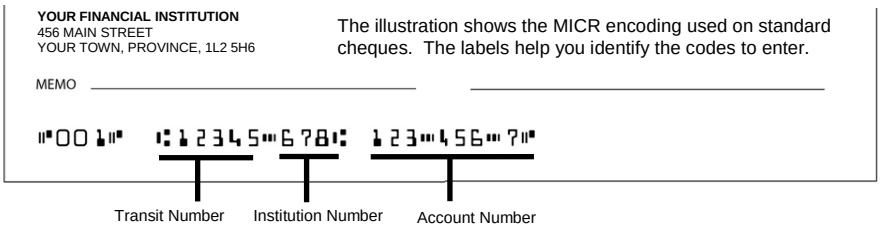
Part C – Direct Deposit

Name of Financial Institution

Address of Financial Institution

Transit No. | Institution No. | Account No.

Direct deposit of claim payments and electronic claim statement.



The illustration shows the MICR encoding used on standard cheques. The labels help you identify the codes to enter.

You will receive your claim payment directly into your account and receive an electronic claim statement.

Your Email

Part D – Privacy Statement

At ASSOCIUM and ASSOCIUM Benefits, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your group plan. You may access and correct, if needed, the personal information in your file by sending us a request in writing. We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. You can find more details about the ASSOCIUM privacy policy at www.associum.com. If you have any questions regarding our privacy policies or about the collection, use and disclosure of your personal information, please contact our Privacy Officer at ASSOCIUM, One Concorde Gate, Suite 802, Toronto, Ontario, M3V 3N6.

Part E– Employee Signature

I hereby apply for group benefits coverage and authorize the deduction from my pay and remittance to ASSOCIUM Benefits any contributions required under the group benefits plan.

I hereby authorize my employer, ASSOCIUM, ASSOCIUM Benefits, MDM Insurance Services Inc. (MDM), the Co-operators Life Insurance Company (Co-operators), Green Shield Canada, the group plan administrator, their agents, or any other person or organization having any relevant information regarding me, my spouse or dependents to release and exchange any and all information necessary for the purposes of determining eligibility for benefits and administration of the group benefits plan.

I authorize ASSOCIUM Benefits, Green Shield and MDM to deposit all payments due to me from the benefit plan, into the bank account that I have identified on this form. I confirm that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future; and shall remain valid until revoked in writing by me. I understand and agree that upon the deposit of any payments into the account ASSOCIUM, ASSOCIUM Benefits, Green Shield and MDM are fully discharged from any further liability with respect to such payments.

I also understand and agree that ASSOCIUM, ASSOCIUM Benefits, Green Shield, and MDM may, at any time and without prior notice, discontinue the direct deposit of payments. I also acknowledge and agree that any payment made by ASSOCIUM, ASSOCIUM Benefits, Green Shield, or MDM into the account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to ASSOCIUM, ASSOCIUM Benefits, Green Shield or MDM, either by me or by representatives of my estate.

I authorize ASSOCIUM, ASSOCIUM Benefits, Green Shield, MDM, the Co-operators Life Insurance Company and the group plan administrator to correspond with me through the email address identified on this form regarding my coverage. I understand such correspondence may contain information; and that the information is being sent in a manner that is not guaranteed as a secure means of communication. I agree that ASSOCIUM, ASSOCIUM Benefits, Green Shield, MDM, the Co-operators Life Insurance Company and the group plan administrator are not liable for damages which may incur as a result of interception by a third party of an email transmission sent by ASSOCIUM, ASSOCIUM Benefits, Green Shield, MDM, the Co-operators Life Insurance Company, the group plan administrator or by me pursuant to this authorization.

Additionally, by signing this authorization, I, an employee under this policy, authorize MDM and Green Shield to release to and exchange with ASSOCIUM and ASSOCIUM Benefits, all personal information regarding myself, and my Insured dependents, including health and dental claims information.

In the event of death, I expressly authorize my beneficiary(ies), heirs(s) or estate liquidator(s) to provide the Co-operators Life Insurance Company or its reinsurers with all the information or authorizations deemed necessary to study the claim and obtain the required proofs. This authorization also applies to my minor children, insofar as applicable to this claim. A photocopy of this authorization is as valid as the original.

I confirm I am authorized to act on behalf of my spouse and/or dependents for the above such purposes. I declare the information provided is true, complete and accurate. Any copy of this authorization shall be valid as the original. I agree to hold harmless ASSOCIUM, ASSOCIUM Benefits, Green Shield, MDM and its employees for any violation under the federal legislation, PIPEDA. I understand this authorization will be valid until the earliest of termination of employment under this policy, or unless cancelled in writing by myself.

X _____

Plan Member's Signature *Date*