



THE EMPIRE LIFE INSURANCE COMPANY
GROUP ENROLMENT FORM

Group Number	Division	Certificate
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To be Completed by Employer

Name of Employer _____

Day	Mo.	Yr.

Date employed Part Time _____ Salary \$ _____ Per _____

Date employed Full Time _____ Commission \$ _____ Per _____

Effective Date of Coverage _____

Hours worked per week _____ Class _____

Department _____ Payroll Number _____

Date _____ Employer's Signature _____

To be Completed by Employee

Last Name _____ Language _____ Prov. of Residence _____

First Name _____ Initial _____ English French

Date of Birth Day Mo. Yr.	Male <input type="checkbox"/>	Single <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>	Occupation
	Female <input type="checkbox"/>	Married <input type="checkbox"/>	Separated <input type="checkbox"/>	Common-Law <input type="checkbox"/>	

Dependant Information (spouse and eligible dependants to be covered). If you have a dependant child over the age of 22, see below.

Last Name	First Name	Relationship	Date of Birth DD/MM/YYYY	Male/Female	Over the Age of 22?
		Spouse			

If more dependants, please attach a separate listing. Overage Dependant Child (age 22 or over) Information:

_____ is a full-time student attending _____, _____, _____, _____
 Dependant Name Name of College/University Course Start Date Course End Date

_____ is an Overage Handicapped dependant. (Please complete and attach Overage Handicapped Dependant form).
 Dependant Name

Is your spouse insured under their employer's group insurance plan (required in the event of Co-ordination of Benefits)? Yes No

If yes, please provide name of spouse's insurance company _____ Type of spouse's coverage: Single Family

Coverage Refusal/Waiver - Understanding the Choice

In respect of total Refusal of, or Waiver of (see Refusal and Waiver options below) any coverage under this Group Plan, I acknowledge that I have been offered the benefits of my employer's Group Insurance Plan with The Empire Life Insurance Company and the benefits provided by this Plan have been fully explained to me. I further acknowledge that I am forfeiting (as indicated below) all my rights and privileges in respect to such benefits. I understand that if I apply for refused or waived coverage in the future, I may be requested to provide evidence of insurability at my own expense.

Total Refusal of Coverage

(Only available under plans with Non-Mandatory participation requirements. See your Plan Administrator for details.)

I waive total coverage for me and my dependants, if any.

Waiver of Extended Health and/or Dental Coverage (Spousal Opt Out)

I, and/or my dependants have coverage with my spouse's group insurance plan and, I/we do not wish to co-ordinate benefits through both plans and therefore I wish to waive the following coverages:

I waive Extended Health coverage for me and my dependants, if any. I waive Dental coverage for me and my dependants, if any.
 I waive Extended Health coverage for my dependants only. I waive Dental coverage for my dependants only.

Spouse's Insurance Company: _____ Type of Spouse's coverage: Single Family

Note: Family coverage will be provided until spouses Insurance carrier information is provided.

Waiver of Long Term Disability

I waive Long Term Disability Coverage as I have Individual Monthly income Disability Insurance. (Attach copy of your individual disability insurance policy face page - LTD coverage will not be waived until a copy is provided.)

CONTINUE ON REVERSE

Beneficiary Designation

Last Name

First Name

Relationship

Percentage Split

If the Beneficiary is a minor, a trustee must be appointed. Trustee: _____

Revocable (Consent of beneficiary **is not** required to change designation.) **Irrevocable** (Consent of beneficiary **is** required to change designation.)

Where Quebec Law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: revocable

Banking Information

We provide the convenience of electronic deposit of claim payments into your bank account. **PLEASE ATTACH A VOID CHEQUE** to use this service.

Authorization for use of SIN (OPTIONAL)

If my employer requires my Social Insurance Number to be used for certificate identification, I hereby authorize The Empire Life Insurance Company to use it for this purpose.

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Authorization

1. I understand that the above personal information concerning me and my dependants is being collected by The Empire Life Insurance Company (Empire) for the object and purpose of:

(a) assessing the risk on a continuing basis and considering whether to issue or renew a group policy of insurance under which I might be or become insured;

(b) determining the premium payable for such insurance;

(c) assessing my eligibility for coverage and the nature and amounts of such coverage;

(d) assessing any claim made by me, my dependants or beneficiaries;

and I authorize Empire, its employees, agents, representatives to collect this information for these purposes and to disclose this information to Empire's agents, representatives, health care providers, other insurance companies or benefit service providers, reinsurers and third-party service providers insofar as such disclosure is required in order to achieve these purposes.

2. I understand that this information will be maintained in a file by Empire and that only Empire's employees, agents, representatives, reinsurers or any other person authorized by me will have access to the file(s) when necessary for achieving the purpose of the file. I also understand that I am entitled to consult the file and, when applicable, have it corrected, and that I can exercise this right by contacting Empire's Head Office.

3. I authorize the policyholder/plan administrator to communicate personal information concerning me and my dependants to Empire in order that my personal information be updated as required for achieving the purpose(s) of the file(s).

4. I also authorize Empire to release to the policyholder/plan administrator and agent of record any group statistical information that may include information concerning claims paid on my behalf or on behalf of my eligible dependants (other than specific details relating to medical condition(s)) for the purpose of negotiating policy renewals, premiums and benefits management.

5. If applying for my spouse and/or dependants, this authorization also applies to the collection use and communication of their personal information, and I confirm that I am authorized to act on their behalf.

6. I hereby apply for benefits, for which I am or may become eligible and authorize payroll deductions, if required.

7. I confirm that a photocopy or electronic copy of this enrolment form and authorization is as valid as the original.

I hereby declare that the above answers and statements are full, complete and true and agree and understand that these answers are material to the risk and form part of the application and consideration for the insurance applied for.

Date _____

Employee's Signature X _____