

Please complete in full and return this form to your Group Benefit Plan Administrator.

A. General Information *(To be completed by the Employer)*

Company _____

Employee / Member Occupation _____ Class _____ Regular hrs/week _____ Annual Earnings _____

New Employee Re-hire Termination Changing Information Reason for Change _____

Permanent full-time hire date DD / MM / YYYY Coverage/Change/Termination Effective Date DD / MM / YYYY

If a re-hire, provide the date previous employment ended DD / MM / YYYY and re-hire date DD / MM / YYYY

(If re-hire is within 6 months, coverage will be effective as of the rehire date; otherwise, the waiting period must be served.)

Signature of Plan Administrator **X** _____ Date DD / MM / YYYY

B. Employee / Member Information *(To be completed by the Employee / Member)*

Employee Name _____ Phone (_____) _____

Address _____ City _____ Province _____ Postal Code _____

C. Employee / Member Family Information – Initial Application or Changing Information *(To be completed by all Employees / Members, regardless of marital/family status)*

| | Surname | Given Name(s) | Date of Birth <i>(DD/MM/YYYY)</i> | Sex <i>(M/F)</i> | Provincial Health Care Coverage in Place? | Dependant Child over the age of 21? ² | Are you, your spouse and/or children covered by any other insurance plan? <i>(Indicate Name of Insurer)</i> | |
|---------------------------|---------|---------------|--------------------------------------|---------------------|---|---|--|---|
| | | | | | | | Health | Dental |
| Employee | | | <u>DD / MM / YYYY</u> | <u>M/F</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | n/a | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Spouse¹ | | | <u>DD / MM / YYYY</u> | <u>M/F</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | n/a | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child | | | <u>DD / MM / YYYY</u> | <u>M/F</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child | | | <u>DD / MM / YYYY</u> | <u>M/F</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child | | | <u>DD / MM / YYYY</u> | <u>M/F</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child | | | <u>DD / MM / YYYY</u> | <u>M/F</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

¹ If your spouse is common-law, please complete the following: I have been living with and representing the above as my spouse since DD / MM / YYYY. My common-law spouse and I are financially responsible for all of our children claimed for insurance purposes. I further verify that I am not obliged to provide coverage for my legal spouse.

² For each Dependant Child age 21 and over:

- For a Student Dependant under age 25, indicate the educational institution where the child is receiving full-time training: _____
- In the case of Dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

| | | | |
|-----------------------------|----------------|----------------|--|
| For Office Use Only: | GMS ID#: _____ | Group #: _____ | Coverage Effective Date: <u>DD / MM / YYYY</u> |
|-----------------------------|----------------|----------------|--|

D. Refusal of Benefits (Complete this section if you wish to refuse enrolment in this group benefit plan)

I have been given the opportunity to apply for coverage but do not wish to participate because I have coverage under my spouse's plan. I understand that I will not be able to enrol in these plans at a later date without the mutual consent of my employer and Group Medical Services.

Waive Health Waive Dental Waive both Health and Dental

X _____ Date DD / MM / YYYY
Signature of Employee / Plan Member

E. Life Insurance Beneficiary Designation (Complete this section if this group benefit plan includes coverage for Life Insurance)

Life Beneficiary

| Full Name of Beneficiaries | Relationship | % Share |
|----------------------------|--------------|---------|
| | | |
| | | |
| | | |

If a designated beneficiary is a minor, I appoint _____ as a Trustee.

Your beneficiary designation will not be revoked or changed automatically by any future marriage or divorce. If you wish to change your beneficiary, you will have to make a new designation below.

Life Beneficiary Change (the effective date of the Beneficiary change will be the date this form is signed)

Change of Name Only Change of Beneficiary Relationship to Employee/Member _____

Name of Beneficiary (last, first, middle initial) _____

X _____
Signature of previous Irrevocable Beneficiary (if applicable)

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of 18.

Coverage for Life, AD&D, Dependant Life, Weekly Indemnity and Long Term Disability is provided by The Co-operators Life Insurance Company ("The Co-operators").

F. Declaration (To be read by the Employee / Member and signed)

I/We ("I") declare the statements made herein are true and complete and shall form part of my application for coverage. I hereby authorize any physician, health care provider, other person, hospital or institution to release to Group Medical Services and/or their designated travel assistance representative(s) (collectively "GMS") any information covering my medical history, symptoms, treatment, examination, diagnosis and/or services rendered to myself or any of my dependants herein listed.

For the purposes of administering any GMS benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS to: (a) collect, store and use any personal information which I have provided to GMS or information obtained pursuant to clause (b); and/or (b) obtain personal information about me (or any other person listed herein) from, or disclose such personal information to: my Government Health Insurance Plan; the operator of any hospital, clinic, or other health facility; a doctor or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required for the purposes described above.

I understand that, whether before or after my application, any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the application may void my coverage. I declare that, if I am signing on behalf of any person(s), I have the authority to sign on behalf of such person(s) and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

If my GMS Group Advantage® plan includes coverage for Life, AD&D, Dependant Life, Weekly Indemnity and Long Term Disability, I understand that these benefits are provided by The Co-operators Life Insurance Company ("The Co-operators") and that GMS acts only as the administrative agent for The Co-operators in placing and administering such coverage. The Co-operators and not GMS has the authority and responsibility for assessing and approving your application for such coverage and any claims made thereunder. As such, any policy providing such coverage, if approved by The Co-operators, will be a contract with The Co-operators and the information you have supplied in this application will be provided to and relied on by The Co-operators and included as part of that contract.

I warrant that neither I nor any person herein listed have any additional coverage through any insurer other than the information listed herein. Should I or any person herein listed subsequently obtain additional coverage through any insurer, while covered under this contract, I will immediately advise GMS in writing. I hereby authorize GMS to co-ordinate any eligible expenses with any additional insurer that I or any person herein listed may have coverage under.

X _____ Date DD / MM / YYYY
Signature of Employee / Plan Member

To avoid delays in processing, ensure all sections of this form are completed in full. When completed, return to your Group Benefit Plan Administrator.