PrimaSure™

my Group Benefits

Enrolment Form

- ❑ Enrolment form **Contract # _____.**
- ❑ Modification form: **Contract # _____, Division # _____.**
  (For modifications please complete sections 1 & 2, as well as the sections that have been modified and the effective date of those changes)

1 INFORMATION TO BE COMPLETED BY PLAN ADMINISTRATOR

Division number	Class	Plan member ID	❑ New plan member ❑ Re-hire	Date of hire/ re-hire *(yyyy-mm-dd)*
Location/billing group number	Location/billing group name	**Contract holder name**		
Effective date of coverage *(yyyyy-mm-dd)*	Occupation	Salary _____$	Basis : ❑ Annual ❑ hourly (hrs./wk._____) ❑ Other: specify: _____	

2 PLAN MEMBER DETAILS

Plan member's last name	First name	Gender ❑ Male ❑ Female	Language ❑ English ❑ French
Address (street number and name)	Apartment or suite	City	
Date of birth (yyyy-mm-dd)	Postal code	Email address	
Province of **employment** :	Province of **residence :**	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Civil union ❑ Widowed ❑ Common law *(date of beginning of cohabitation* : _____)	

3 DEPENDENT DETAILS

SPOUSE's last name	**SPOUSE's** first name	Date of birth *(yyyy-mm-dd)*	Gender ❑ Male ❑ Female

Is your **spouse** covered for Extended Health Care and/or Dental Care benefits by his/her employer's plan?

❑ No;
❑ Yes. If yes, please indicate the name of the insurer as well as your spouse's coverage. My **spouse**'s insurer is : _____

Spouse's Extended Health Care : ❑ Family ❑ Individual ❑ Single Parent ❑ Couple ❑ No coverage
Spouse's Dental Care : ❑ Family ❑ Individual ❑ Single Parent ❑ Couple ❑ No coverage

CHILD's legal last name	**CHILD**'s legal first name	Date of birth *(yyyy-mm-dd)*	**Sex**	**Student***	**Over-age disabled child****
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No
			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No

* A student is a child age 21 or over but under age 30, who is a full-time student attending an educational institution recognized by Canada Revenue Agency, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support.

** To enrol an over-age disabled child, complete a Disabled Child Coverage form, and send it to us within 31 days of the date the dependent reaches the age limit.

4 COVERAGE REQUESTED FOR BENEFITS

Coverage requested – **Extended Health Care**
❑ Individual ❑ Single Parent ❑ Couple ❑ Family ❑ Exempted*****
Coverage requested – **Dental Care** *(if dental is stipulated in the contract)*
❑ Individual ❑ Single Parent ❑ Couple ❑ Family ❑ Exempted*****

****In order to choose exemption from extended health care and/or dental care coverage, you must be covered on another group insurance contract with similar coverage.***

IMPORTANT: for health and/or dental, please make sure to properly complete **section 3** if you are asking for single parent, couple or family coverage, as well as if you are asking for individual coverage even though you have a spouse.

5 BENEFICIARY NOMINATION

Beneficiary for **Employee BASIC Life** and **Accidental Death Benefits (if applicable).** You must initial any changes or deletions. Correction fluid cannot be used.

Last name	First name	Relationship to plan member	Percentage
			%
			%
			%
			%
Other			
In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, **THIS BENEFICIARY WILL BE IRREVOCABLE UNLESS YOU CHECK THE REVOCABLE BOX**. ❑ Revocable beneficiary			

IMPORTANT NOTES:

If you do not nominate a beneficiary, the proceeds will be paid to your estate.

In order to appoint contingent beneficiaries or a trustee for a beneficiary that is a minor, please attach the Beneficiary Nomination form.

*In Quebec, if at the time of the claim, your beneficiary(ies) are minors, payments of the policy will be made to the parents or the legal trustee of that beneficiary(ies). In all other provinces you must fill out the supplementary form to designate the minor's trustee.

6 AUTORIZATION AND SIGNATURE – *you must sign and date the form*

I am authorized to disclose information about my spouse and dependents in order to enrol them in the plan.

By enrolling in this plan, I authorize the following:

- Sun Life Assurance Company of Canada and its reinsurers to collect, use and disclose relevant information about me to underwrite, administer, adjudicate and deposit claim payments,
- My plan sponsor to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required,
- Nexim Canada and the insurance carrier(s) to collect, use and disclose information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the plan.

I declare that the information above is accurate and true.

A photocopy or electronic version of this authorization is as valid as the original. A photocopy or electronic version of this form is not valid for recording beneficiary nominations.

For any future correspondence please have documents sent to me in: ❑ English or ❑ French

Plan member's signature X	Date *(yyyy-mm-dd)*