



ENROLMENT FORM

PLEASE PRINT AND COMPLETE EACH SECTION CLEARLY IN INK.
REMIT SIGNED ORIGINAL TO RWAM AND KEEP A COPY FOR YOUR RECORDS.

Certificate # _____

EMPLOYER DATA

Employer _____ Group# _____ Div.# _____ Class _____ New Reinstatement

Permanent Full-time Hire Date _____ Description of Occupation _____
(Reinstatements indicate date of re-hire) (yy/mm/dd)

Earnings _____ Hours worked (per week) _____
(Excluding Bonus/Dividend/Overtime Income)

Salary (annual) Bi-Weekly Weekly
 Hourly Monthly

EMPLOYEE STATEMENT

You and your dependents must be insured under your Provincial Benefit Plan in order to participate in RWAM's group insurance plan.

Employee's Surname _____ First Name _____

Date of Birth _____ Sex Female Male Address _____
(yy/mm/dd)

Marital Status
 Single Common-law* Separated Married Divorced Widowed

*If Common-law, indicate date co-habitation began _____
(yy/mm/dd)

SINGLE, Extended Health Care
 SINGLE, Dental

If you are eligible for family coverage your dependents must have coverage* through your spouse

Spouse's Employer _____
 Spouse's Group Insurance Carrier _____

FAMILY, Extended Health Care
 FAMILY, Dental

Please indicate if you have coverage* through your spouse
 E.H.C. No Yes
 Dental No Yes
 If 'Yes' indicate Spouse's Group Insurance Carrier _____

Claims must be submitted to the primary carrier first. Any portion of the claim not reimbursed by the primary carrier should be sent to the secondary carrier for consideration. Children's claims are reimbursed by the plan of the parent whose date of birth falls first in the calendar year.

WAIVE, Extended Health Care
 WAIVE, Dental

To waive coverage you and your dependents must have coverage* through your spouse.

Spouse's Employer _____
 Spouse's Group Insurance Carrier _____

* If comparable coverage ceases, you must notify RWAM within 31 days or you will be subject to medical evidence (at your expense) and a one year dental restriction.

ELIGIBLE DEPENDENTS

Name <small>(state surname if different than employee's)</small>	Date of Birth <small>(yy/mm/dd)</small>	Name <small>(state surname if different than employee's)</small>	Relationship to Employee	Date of Birth <small>(yy/mm/dd)</small>
Spouse _____	_____	Children* _____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Students aged 21 or over and under 25 (or as specified in your plan) are only eligible if they submit confirmation of full-time registration.

*Children of common-law spouses must reside with the employee to be eligible.

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. A separate Beneficiary Designation/Change form is required to name contingent beneficiaries.

Beneficiary (ies) *à Name(s) <small>(first, middle initial, last)</small>	Relationship to Insured	% Shares <small>(must = 100%)</small>
_____	_____	_____%
_____	_____	_____%
_____	_____	_____%

Trustee * If a beneficiary is under age 18: Consider naming a Trustee as benefits cannot be paid to a minor. Benefits will be paid to the named Trustee (regardless of beneficiary age) unless you change the designation to remove the Trustee.

Trustee Name <small>(first, middle initial, last)</small>	As Trustee for <small>(beneficiary name)</small>	Relationship to Beneficiary
_____	_____	_____

AUTHORIZATION

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by myself.

Employee's Signature X _____ Date _____ (yy/mm/dd)

OFFICE USE ONLY

Effective Date	Life Volume <input type="radio"/> GF	WI Volume <input type="radio"/> GF	LTD Volume <input type="radio"/> GF	Extended Health Care <input type="radio"/> Single <input type="radio"/> Family <input type="radio"/> Nil	Dental <input type="radio"/> Single <input type="radio"/> Family <input type="radio"/> Nil
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APPLICATION FOR DIRECT DEPOSIT OF GROUP BENEFIT PAYMENTS

BENEFITS OF DIRECT DEPOSIT

Direct Deposit of Group Benefit Payments (otherwise known as Electronic Funds Transfer or 'EFT') allows RWAM to deposit your approved benefit payments directly into your personal/joint bank account.

A corresponding Explanation of Benefits ('EOB') statement will be sent to you, explaining the benefit payment.

Advantages of this convenient service include:

- Quick, safe and confidential
- Eliminates risk of lost or delayed benefit cheques
- Convenient, no extra trips to the bank
- Less paper, environmentally friendly

EMPLOYEE & BANKING INFORMATION

Employee Name _____ Group # _____ Certificate # _____

Attach Your Personal Account Cheque Marked "VOID"

Send my EOB to my personal e-mail address* at _____

Return this form and your VOID cheque by mail to: **RWAM Group Administration Department**
49 Industrial Drive
Elmira, ON N3B 3B1

If a void cheque is not included, complete the following:

Name(s) of Account Holder _____

Name & Address of Financial Institution _____

Bank # _____ Branch # _____ Account # _____

NOTES:

- You must be the sole or **joint** (generally jointly with your spouse) account holder & have signing authority.
- Applications for deposit to a third party's account will be rejected.

* **Disclaimer:** The transfer of any personal information by e-mail is not 100% secure. Your consent to transfer information by e-mail is given with this knowledge and understanding, and RWAM Insurance Administrators Inc. does not accept any responsibility for any interceptions of e-mails by unauthorized parties.

AUTHORIZATION

I hereby authorize RWAM Insurance Administrators Inc. to deposit Group Benefits (Extended Health, Dental and/or Disability) payments directly to my personal/joint bank account and to exchange my relevant financial information with my financial institution for such purposes. This authorization shall remain valid until revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Employee Signature **X** _____ Date (yy/mm/dd) _____

