Enrolment Form

eSignature option: Certificate of Completion must accompany this form.
Handwritten option: Complete in ink, with any corrections initialed. A copy should be kept for your records and is considered as valid as the original.
Send completed form to: csr-groupadmin@rwam.com or mail to RWAM at address noted below.

EMPLOYER SECTION

○ New ○ Reinstatement

OFFICE USE ONLY
Certificate #

Employer		Group #	Div.	Class
Employee Last Name	First Name	Date of Birth (yyyy/mm/dd)	○ Male ○ Female	
Permanent Full-time Hire Date (yyyy/mm/dd)	Reinstatements - Rehire Date (yyyy/mm/dd)	Description of Occupation		
Earnings (exclude bonus/dividend/overtime income)	○ Salary (annual) ○ Bi-Weekly ○ Weekly ○ Hourly ○ Bi-Monthly ○ Monthly		Hours Worked (per week)	

EMPLOYEE STATEMENT

Employee (You) must meet all eligibility requirements as noted in the Employee Benefits Booklet. You and your dependent(s) must be insured under your Provincial Benefit Plan to participate in this group insurance plan.

Marital Status ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed ○ Common-law →

Date Co-habitation Began (yyyy/mm/dd)

Address #, Street	City, Prov.	PC
		select

Personal email for claim reimbursements (EOB) and electronic form submissions

BENEFIT SELECTION

Extended Health Care	○ Single	○ Family	○ Waive	○ Coverage not applicable to this group plan
Dental Care	○ Single	○ Family	○ Waive	○ Coverage not applicable to this group plan

Does spouse have comparable coverage? ○ n/a ○ Yes ○ No If 'Yes', ☐ EHC ☐ Dental

Spouse's Employer	Spouse's Insurance Company

Single If you are eligible for 'Family' coverage but have selected 'Single', your dependent(s) must have coverage through your spouse.

Family If you are eligible for and have selected 'Family' coverage, all eligible dependent(s) must be listed below.
Claims must be submitted to the primary carrier first. Any portion of 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 To waive coverage (EHC and/or Dental), you and your dependent(s) must have coverage through your spouse.

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

ELIGIBLE DEPENDENTS

Complete if family coverage has been selected. Spouse/Common-law spouse is considered a dependent.

	First Name	Last Name	Date of Birth (yyyy/mm/dd)	Relationship to Employee
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				
Dependent 5				
Dependent 6				
Dependent 7				

Students aged 21 or over and under 25 (or as specified in your plan) are only eligible if they submit confirmation of full-time student status.
Children of common-law spouse 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 any group life insurance benefits payable on my death. If more than one person is named, proceeds are to be shared equally, unless otherwise stated below. Note: A separate Beneficiary Designation/Change form is required to name contingent beneficiary(ies).

	Name (first name, surname)	Relationship to Insured	% Share (total must = 100%)
Beneficiary 1			
Beneficiary 2			
Beneficiary 3			
Beneficiary 4			
Beneficiary 5			

TRUSTEE - If a beneficiary is under age 18, consider naming a trustee, as benefits cannot be paid to a minor. Group Life Insurance benefits will be issued according to the Insurer's guidelines.

	Trustee Name (first name, surname)	Trustee for (Beneficiary name) if Beneficiary is under 18	Relationship to Beneficiary
Trustee 1			
Trustee 2			

OFFICE USE ONLY	Effective Date	Life Vol. ☐ GF	STD Vol. ☐ GF	LTD Vol. ☐ GF	EHC ☐ S ☐ C ☐ F ☐ N	Dental ☐ S ☐ C ☐ F ☐ N

Employer		Group #	Div.	Class
Employee Last Name	First Name			

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 or joint bank account (your name must be on the account).
RWAM will email you an Explanation of Benefits (EOB) statement after receiving your submitted claims, indicating the benefit payment and/or decision.

Financial Institution					
Address	#, Street		City, Prov.		
Branch/Transit #	5 digits	Financial Institution #	3 digits	Account #	

If account # starts with '0', be sure to include it.
Do not use dashes, hyphens, or any other punctuation.

NOTE:

- If you do not have cheques and are unfamiliar with how to complete the above, contact your financial institution to make sure you are providing RWAM with the correct information.
- Inaccurate or missing information can result in delays or errors.
- You must be the sole or joint (generally jointly with your spouse) account holder at a Canadian financial institution and have signing authority.
- Applications for deposit to a third party's account will not be accepted.
- Paper (non-electronic) submissions can include a Direct Deposit form (obtained from your financial institution) or a cheque marked 'void' to validate account numbers.

AUTHORIZATIONS

Enrolment

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 or Reinsurer to exchange any relevant and necessary information for such purposes. I authorize my employer to deduct from my pay and remit to RWAM any applicable group benefit contributions. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. This authorization is also valid, in the event of my death, regarding any person, beneficiary(ies) or organization including any medical and professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrator holding information required by the insurer, or its service providers, that may be required for the processing of my file. 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 (original or photocopy) will remain valid for as long as I am claiming benefits or service, until revoked by me in writing.

Direct Deposit

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. I authorize correspondence with me through the email address indicated on the Employee Statement section of this form. I understand such correspondence may contain personal information and that the information is being sent in a manner that is not guaranteed as a secured means of communication. 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	Certificate of Completion must accompany this form with eSignatures	Date	

RWAM Insurance Administrators Inc. is committed to protecting the privacy, confidentiality, accuracy, and security of personal information it collects, uses, retains, or exchanges in the necessary conduct of our business.