

OFFICE USE ONLY

eSignature option: Handwritten option: Send completed form to:  $\label{lem:completion} \mbox{Certificate of Completion must accompany this form.}$ 

Complete in ink, with any corrections initialed. A copy should be kept for your records and is considered as valid as the original. <a href="mailto:csr-groupadmin@rwam.com">csr-groupadmin@rwam.com</a> or mail to RWAM at address noted below.

EMPLOYER SECTION New Reinstatement						OFFICE USE ONLY Certificate #				
Employer							Group #		Class	
Employee Last Name First Name				Date of Birth (yyyy/mm/dd)		Male	Female			
Permanent Full-time Hire Date (yyyy/mm/d	Reinstatemen	ts - 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)						
MPLOYEE STATEMENT mployee (You) must meet all eligibility articipate in this group insurance plan.	requirements as note	ed in the Emplo	yee Benefits B	ooklet. You ar	nd your depender	nt(s) must be insured unc	der your Pr	ovincial Benefi	t Plan to	
1arital Status Single						Common-law →	mmon-law → Date Co-habitation Began (yyyy/mm/dd)			
Address #, Street				Cit	y, Prov.			PC		
Personal email for claim reimburseme	nts (EOB) and electro	nic form submi	ssions							
ENEFIT SELECTION										
Extended Health Care Single Dental Care Single	Family Family	Waive Waive			o this group plan o this group plan					
Does spouse have comparable covera	ge? n/a	Yes N	0	If 'Yes',	EHC	Dental				
Spouse's Employer				Spouse's I	nsurance Compai	ny				
Vaive To waive coverage (EHC and comparable coverage ceases, RWAM LIGIBLE DEPENDENTS Complete if fr	must be notified with	in 31 days or yo	ou will be subj	ect to medical	evidence (at you	r expense) and a dental r	estriction (	may apply.		
·	First Name			t Name	•	of Birth (yyyy/mm/dd)	Rela	tionship to Empl	oyee	
Dependent 1										
Dependent 2										
Dependent 3										
Dependent 4										
Dependent 5 Dependent 6										
Dependent 7										
Students aged	21 or over and under Imon-law spouse mu				gible if they subm	it confirmation of full-tin	ne student	status.		
BENEFICIARY DESIGNATION  I revoke all prior beneficiary designation person is named, proceeds are to be sha										
	Name (fi	rst name, surname)			Rela	tionship to Insured		% Share (total mu	st = 100%)	
Beneficiary 1										
Beneficiary 2										
Beneficiary 3 Beneficiary 4										
Beneficiary 5										
RUSTEE - If a beneficiary is under age 1	<b>8</b> , consider naming a t	rustee, as bene	fits cannot be	paid to a minor	. Group Life Insur	ance benefits will be issue	d accordin	g to the Insurer	's guidelines.	
	stee Name (first name, surna	ame)		Trustee for (Ber	eficiary name) if Bene	ficiary is under 18		Relationship to B	eneficiary	
Trustee 1 Trustee 2										

□S □C □F □N

□S □C □F □N

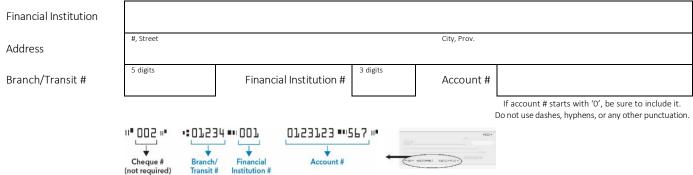


Enrolment Form - Pg. 2

Employer		Group #	Div.	Class
Employee Last Name	First Name	ı		

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.



## 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		Date	
	Certificate of Completion must accompany this form with eSignatures		

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.