



ENROLMENT FORM

- PLEASE PRINT and complete each section clearly in ink.
- Remit a signed original to RWAM and keep a copy for your records.
- Employee must meet all eligibility requirements as noted in the Employee Benefits Booklet.
- You and your dependents must be insured under your Provincial Benefit Plan in order to participate in RWAM's group insurance plan.

Certificate # _____

EMPLOYER DATA

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

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

Earnings _____ (Excluding Bonus/Dividend/Overtime Income) Salary (annual) Bi-Weekly Weekly Hourly Monthly Bi-Monthly Hours worked _____ (per week)

EMPLOYEE STATEMENT

Employee's Surname _____ First Name _____

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

Marital Status: Single Common-law* Separated Married Divorced Widowed
 * If Common-law, indicate date co-habitation began (yy/mm/dd) _____

Address (#, Street, City & PC) _____

Email - necessary for online claims submissions _____

SINGLE, Extended Health Care SINGLE, Dental FAMILY, Extended Health Care FAMILY, Dental WAIVE, Extended Health Care WAIVE, Dental

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

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

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.

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 (state surname if different than employee's)	Date of Birth (yy/mm/dd)	Relationship to Employee
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 student status.
 * 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)	% Shares	Trustee * If a beneficiary is under age 18:
Name(s) - first & last	Relationship to Insured	(must = 100%)
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 & last)	As Trustee for (beneficiary name)	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 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, with regard to 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 require 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 myself.

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

OFFICE USE ONLY

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

Necessary for online claims submissions

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 or joint bank account (your name must be on the account).

You will be e-mailed once your claim is processed, and a corresponding Explanation of Benefits ('EOB') statement will be made available to you, explaining the benefit payment and/or decision.

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, and it's more environmentally friendly.

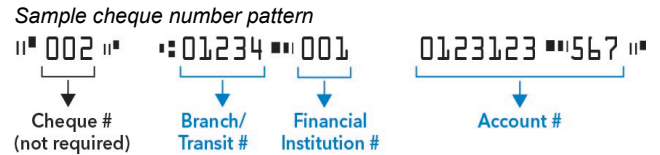
EMPLOYEE & BANKING INFORMATION

Employee Name _____ Group # _____ Certificate # _____

Send my Explanation of Benefits (EOB) to my personal e-mail address at _____

Attach Your Cheque Marked "VOID"
If you do not have a chequing account, we recommend that you confirm the account information you are providing with your financial institution.

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



Name(s) of Account Holder (as it appears on the cheque) _____

Name & Address of Financial Institution _____

Financial Institution # _____ (3 digits) Branch/Transit # _____ (5 digits) Account # _____
(If your Acct. # starts with zero, be sure to include the zero. Do not include dashes, hyphens or any other punctuation.)

- NOTES:**
- If you don't have cheques and are unfamiliar with how to complete the above, contact your financial institution or your Plan Administrator 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 & have signing authority.
 - Applications for deposit to a third party's account will be rejected.

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. I authorize correspondence with me through the email address indicated on 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 x _____ Date (yy/mm/dd) _____

Return this form and your VOID cheque by mail, fax or email to:

RWAM Group Administration Department
49 Industrial Drive, Elmira, ON N3B 3B1
Fax: 519-669-1923
email: csr-groupadmin@rwam.com

