



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 _____ Description of Occupation _____
(Reinstatements indicate date of re-hire) (yy/mm/dd)

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

FAMILY, Extended Health Care FAMILY, Dental ⇒ 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 (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)	Relationship to Insured	% Shares (must = 100%)	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.
Name(s) - first & last _____	_____	_____ %	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 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. 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="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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FOR DIRECT DEPOSIT OF BENEFITS COMPLETE REVERSE

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