

GROUP LIFE
& HEALTH



APPLICATION

Well.
And well worth it.



The Standard Life Assurance Company of Canada

www.standardlife.ca

INSTRUCTIONS FOR THE PLAN ADMINISTRATOR
I Administrative information

The information you provide in this section will allow us to cover each participant in accordance with the specifications of your group insurance plan. Effective date of insurance corresponds to the participant's date of employment plus the eligibility period stipulated in your contract.

If your insurance plan includes a Health Spending Account which provides variable annual allocations per participant, please specify the participant's variable allocations.

Please return this form to Standard Life within thirty-one days following the participant's eligibility date. After this date, evidence of insurability may be requested from the participant and his/her dependents, if any.

If you need assistance in completing section I, do not hesitate to contact our Customer Service Representatives.

INSTRUCTIONS FOR THE PARTICIPANT

Your employer has chosen a plan tailored to the specific needs of your group. To be covered under the plan, please remit the completed and signed Application to your Plan Administrator.

Please advise your Plan Administrator if you do not wish your Social Insurance Number to be used as your Certificate Number within your group plan and as your identification number in Standard Life's database.

For more information on your enrollment and on the optional benefits offered under your plan, please contact your Plan Administrator.

**BEFORE REMITTING YOUR APPLICATION,
PLEASE ENSURE YOU HAVE PROVIDED ALL INFORMATION REQUESTED.**

II Administrative information
Direct Deposit

Direct deposit is the preferred method of payment at Standard Life. Please complete the box provided in section II and attach a personalized "VOID" cheque to your Application. If you have a savings account, please provide all information requested concerning your savings account.

III Information on dependent(s)

- If the space provided to list dependent information is insufficient, please use another copy of this form.
- Coordination of benefits:
In order to determine who the primary insurer will be for the payment of claims, it is important to provide the information on existing dependent's coverage under another group insurance plan.
- Confirmation of school attendance:
Complete section VII for each dependent child who has reached the first age limit specified in the plan (generally between 18 and 21 years of age).
- Confirmation of disabled status-dependent children:
For each disabled dependent child who has reached the first age limit specified in your contract (generally between 18 and 21 years of age), complete *Confirmation of total and permanent disability of a dependent child* form GE10352 and attach it to this Application.

V Choice of coverage

- Except when specified otherwise, you will be provided with family coverage if you complete section III and your dependents are eligible. If you choose single coverage, your dependents will not be covered for any benefits offered under your plan.
- For Québec employees only:
Under the Prescription Drug Insurance Act, your dependents must be covered under the health benefit provided by your employer's plan, unless they are already covered under another group insurance plan.

VI Exemption request for benefits already covered under your spouse's group insurance plan

- You and/or your dependents may choose to decline health and/or dental care coverage if these benefits are already provided under your spouse's group insurance plan.

VIII Beneficiary designation

- If no beneficiary is specified, our records will show "Estate" as the beneficiary.

IX Québec participants only

(to be completed if beneficiary is your spouse – marriage or civil union)

- Only Québec participants who designate their spouse, excluding common-law spouse, as beneficiary in section VIII must complete this section.
- If your beneficiary designation is irrevocable, please note that you cannot change your designation unless the beneficiary aged 18 or over signs a waiver of rights (form GE8003).

X Declaration appointing trustee

(to be completed if beneficiary is under legal age)

- Unless you have appointed a trustee in your will, we recommend that you complete this section if you have designated a beneficiary who is a minor.

PLAN ADMINISTRATOR STATEMENT

I Administrative information (please print)											
Policyholder name							Policy no.		Division no.		
Participant surname				Given name(s)			Initial	Certificate no.			
Date of permanent full-time employment (with present employer)				(YYYY/MM/DD)		Eligibility date of insurance				(YYYY/MM/DD)	
Occupation		Class	Salary		Salary basis:			Hours worked per week			
					<input type="checkbox"/> Annual	<input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Hourly				
					<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly					
Health Spending Account											
Variable allocations			Combined: \$			or Health: \$			Dental: \$		

PARTICIPANT STATEMENT

II Administrative information (please print)											
Language:	Gender:	Date of birth (YYYY/MM/DD)			Marital status:			If common-law, date on which cohabitation period started			
<input type="checkbox"/> English	<input type="checkbox"/> M	/ /			<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Common-law	(YYYY/MM/DD)		
<input type="checkbox"/> French	<input type="checkbox"/> F	/ /			<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Civil union	/ /			
Native Canadian status		Main residence address (no., street)								Apt.	
<input type="checkbox"/> Yes <input type="checkbox"/> No											
City			Province of residence			Workplace Province (if different than province of residence)			Postal code		
Telephone no. (day)					Telephone no. (evening)						
()					()						
Direct deposit											
Type of bank account:				Branch no.		Institution no.		Account no.			
<input type="checkbox"/> Chequing (please attach a personalized VOID cheque)											
<input type="checkbox"/> Savings (please complete the following section)											
Financial institution name					Financial institution address						
Account holder signature (if other than participant)							Date				
							(YYYY/MM/DD)				
							/ /				

III Information on your dependent(s)

	Surname	Given name(s)	Gender	Date of birth	Are your spouse and/or your children covered by another group insurance plan? ¹				Full-time student ²	Total and permanent disability ³
					Health Care		Dental Care			
			M F	YYYY/MM/DD	Yes	No	Yes	No		
Spouse			<input type="checkbox"/> <input type="checkbox"/>	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¹ If your spouse and/or children are covered under another group insurance policy, please complete section IV.

² If you have dependent children who have reached the first age limit stipulated in the contract, please complete section VII.

³ If you have disabled dependent children who have reached the first age limit stipulated in the contract, please complete Confirmation of total and permanent disability of a dependent child form GE10352 and attach it to this Application.

IV Information about your spouse's group insurance plan

Name of your spouse's group insurer				Policy no.		Coverage:		Health Care:		<input type="checkbox"/> Individual <input type="checkbox"/> Family	
								Dental Care:		<input type="checkbox"/> Individual <input type="checkbox"/> Family	

V Choice of coverage

- Individual coverage (only the participant is covered) Family coverage (the participant and his/her eligible dependents are covered)

VI Exemption request for benefits already covered under your spouse's group insurance plan

I decline health insurance benefits: For myself and my dependents
 For my dependents only
 I decline dental care benefits: For myself and my dependents
 For my dependents only

VII Confirmation of school attendance *(dependent children who have reached the first age limit)*

Given name(s)	Name of educational institution attended on a full-time basis	Attendance period		Telephone no. of institution
		Start (YYYY/MM/DD)	End (YYYY/MM/DD)	
		/ /	/ /	()
		/ /	/ /	()
		/ /	/ /	()

The Standard Life Assurance Company of Canada reserves the right to confirm student status with the educational institution.

VIII Beneficiary designation

Beneficiary surname	Given name(s)	Relationship to participant	%

If the designated beneficiary is legal heirs or estate, please write in full "Legal heirs" or "Estate" and do not provide name(s), given name(s) or relationship to participant. If you wish to designate a contingent beneficiary, please complete the *Beneficiary Designation* form (GE9874).

IX Québec participants only *(to be completed if beneficiary is your spouse – marriage or civil union)*

In Québec, the designation of a spouse, excluding common-law spouse, as beneficiary is irrevocable unless otherwise specified. If you designate your spouse as beneficiary, Standard Life recommends that you make a revocable designation in order to facilitate any future request for a change of beneficiary. An irrevocable designation cannot be changed unless the beneficiary aged 18 or over signs a waiver of rights.

Please sign in the box corresponding to your choice ONLY IF you designate your SPOUSE as beneficiary.

The beneficiary designation is **revocable**

The beneficiary designation is **irrevocable**

	or	
Participant signature		Participant signature

X Declaration appointing trustee *(to be completed if beneficiary is under legal age)*

I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under legal age and I declare that the receipt from such Trustee shall be a valid discharge to Standard Life of the amount so paid. I also hereby authorize such Trustee at his/her discretion to apply on behalf of such beneficiary the whole or any portion of such amount and the income derived therefrom for the care, maintenance, education, advancement in life or other benefit of such beneficiary.

Participant signature	Date (YYYY/MM/DD)
	/ /

XI Optional benefits

Please verify with your Plan Administrator if optional benefits are offered under your plan. If so and if you wish to apply for these benefits, please complete Optional Benefits form GE8002 and indicate whether coverage is for:

Yourself Your spouse Your dependent children

Please note that optional life benefits are subject to evidence of insurability and come into effect only when approved.

XII Authorization

I hereby accept the conditions of this policy and I authorize the necessary contributions to be made through salary deductions, if applicable.
I consent to the use of my Social Insurance Number as my Certificate Number under the group plan and as my identification number in the Standard Life database, and that it is my responsibility to advise my Plan Administrator if I do not wish my Social Insurance Number to be used to identify me under the group plan.
I authorize my employer, the Policyholder, the Plan Administrator, The Standard Life Assurance Company of Canada or their reinsurers, their respective agents to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any under this plan.
I authorize Standard Life to deposit all benefits from my claims in the designated bank account.
In the case of death, I expressly authorize my employer, the Policyholder, the beneficiary, heir or liquidator of my estate to provide The Standard Life Assurance Company of Canada, when required by the latter, with all the information and authorizations permitting the assessment of the claim and the collection of evidence.
This consent is valid for the purpose of this contract, or any modification, extension or reinstatement thereof.
A photocopy of this consent is valid as the original if it is used for information-sharing purposes.

Participant signature	Date (YYYY/MM/DD)
	/ /