ENROLMENT FORM

Certificate # ____________

PLEASE PRINT AND COMPLETE EACH SECTION CLEARLY IN INK
REMIT SIGNED ORIGINAL TO RWAM

EMPLOYER DATA

Employer ______________________ Group# ____________ Div.# ________ Class ________ ○ New ○ Reinstatement

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

Description of Occupation ______________________

Earnings ______________________
(Bonus/Dividend/Overtime Income is excluded)

○ Salary (annual) ○ Bi-Weekly ○ Weekly
○ Hourly ○ Monthly

Hours worked (per week) ____________

EMPLOYEE STATEMENT

You and your dependents must be insured through your Provincial Benefit Plan in order to participate in RWAM's group insurance plan.

Employee's Surname ______________________ First Name ______________________

Date of Birth ______________ (yy/mm/dd)

Sex ○ Female ○ Male

Address ______________________

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

* If Common-law, indicate date co-habitation began ______________ (yy/mm/dd)

○ **SINGLE, Extended Health Care**
○ **SINGLE, Dental**
4

If you are eligible for family coverage your dependents must have coverage* through your spouse
Spouse's Employer ______________________
Spouse's Group Insurance Carrier ______________________

○ **FAMILY, Extended Health Care**
○ **FAMILY, Dental**
4

Please indicate if you have coverage* through your spouse
E.H.C. ○ No ○ Yes
Dental ○ No ○ Yes
If "yes" – Spouse's Group Insurance Carrier ______________________

Claims must be submitted to the primary carrier, indicated above, first. Any portion of the claim not reimbursed by the primary carrier should be sent to the spouse's insurance company for consideration. The children's claims will be reimbursed under the parent whose date of birth falls first in the calendar year.

○ **WAIVE, Extended Health Care**
○ **WAIVE, Dental**
4

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, please advise RWAM within 31 days or you will be subject to medical evidence (at your expense) and a one year dental restriction.

ELIGIBLE DEPENDENTS

	Name (list surname if different than employee's)	Relationship to Employee	Date of Birth (yy/mm/dd)
Spouse			
Children			

* Students over 21 and under 25 are only eligible if they submit proof of full-time registration.
Children of common-law spouses must reside with the employee in order to be eligible.

BENEFICIARY DESIGNATION

Full Legal Name of Beneficiary ______________________
First Name Surname

Relationship To Employee ______________________

Trustee (If Beneficiary is under 18) ______________________

Application to remove trustee must be made once the Beneficiary turns 18 years of age.
All changes/corrections must be initialled by the applicant.

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. 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 revoked by myself.

Employee's Signature X______________________ Date ______________ (yy/mm/dd)

OFFICE USE ONLY

Effective Date	Life Volume ○ GF	WI Volume ○ GF	LTD Volume ○ GF	Extended Health Care ○ Single ○ Family ○ Nil	Dental ○ Single ○ Family ○ Nil

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