



MEMBER APPLICATION

Member: Please print clearly, complete sections 1-4 and sign section 5. Pass this form onto your Plan Administrator after you have completed it.

Plan Administrator: Please complete sections 6, sign section 7 and submit to Sirius Benefit Plans. Section 8 is for Sirius Benefit Plan use only.

1	Member Information	Last Name		First Name			
		Street Address		City	Prov	Postal Code	
		Gender <input type="checkbox"/> male <input type="checkbox"/> female	Date of Birth DD / MM / YYYY				
		Marital Status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> widowed <input type="checkbox"/> divorced <input type="checkbox"/> common-law			Date of co-habitation: DD / MM / YYYY		

2	Other Coverage	Do you have coverage under your Spouse's EHC program?		<input type="checkbox"/> no	<input type="checkbox"/> yes	Insuring Company _____
		If yes: do you wish to opt out of this plan?		<input type="checkbox"/> no	<input type="checkbox"/> yes	
		do you wish to cover your spouse under this plan?		<input type="checkbox"/> no	<input type="checkbox"/> yes	
		Do you have coverage under your Spouse's Dental program?		<input type="checkbox"/> no	<input type="checkbox"/> yes	Insuring Company _____
If yes: do you wish to opt out of this plan?		<input type="checkbox"/> no	<input type="checkbox"/> yes			
do you wish to cover your spouse under this plan?		<input type="checkbox"/> no	<input type="checkbox"/> yes			

3	Dependent Information	Name		Date of Birth	Sex M or F	Relationship	For over-age dependent children see booklet for definitions of each		
		Last	First					Full-time University or College Student?*	Disabled Dependent?*
				DD / MM / YYYY				Yes or No	Yes or No?
				DD / MM / YYYY					
				DD / MM / YYYY					

*Please complete an overage dependent application if the dependent child is attending college or university (secondary education) or if you wish to submit your dependent child as an overage disabled dependent. Your booklet has information regarding both these two situations.

4	Beneficiary	Name		Relationship to Member	Percentage cannot exceed 100% in total	For Quebec residents only: The beneficiary is considered irrevocable unless you check here <input type="checkbox"/> , which then identifies that the beneficiary is revocable.
		Last	First			

Trustee Designation
This section is to be completed only if the beneficiary designated above is under the age of majority

I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under the age of 18.

5 I consent to the collecting, using and disclosing of my personal information for the purposes of communication, underwriting risks, investigating and adjudicating claims, detecting and preventing fraud, compiling statistics and acting as required or authorized by law. I certify that all information in this form is true and accurate. I hereby apply for coverage for which I am, or may become, eligible for. I acknowledge that I only enroll, at this time or any future time, dependents who have authorized me to provide their information and consent to the collection, use and disclosure of their information for the above purposes. I authorize Sirius Benefit Plans, any insurance companies and healthcare providers to exchange information when necessary to determine eligibility and to administer the plan. I designate the above mentioned beneficiary for any benefits payable as a result of my participation in this plan.

Member Signature	Date Signed	DD / MM / YYYY
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6	Plan Administrator	Group #	Firm #	Class	Name of Firm		
		Occupation	Date of Hire DD / MM / YYYY	Date of Full-time DD / MM / YYYY	# of Hrs Each Week	Gross Monthly Earnings \$	

7 I confirm that this employee is eligible for coverage and that the information provided is true and accurate.

Plan Administrator Signature	Date Signed	DD / MM / YYYY
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Eff date _____
Class _____
Member _____
Cert _____
Firm _____
Group _____
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