ENROLMENT OR CHANGE FORM

AOM Benefits Trust

This form must be signed in ink. If you are changing your beneficiary designation, please return the original signed form by mail to the AOM Benefits Trust. All other changes can be sent by email, mail, or fax. Our contact information is on the second page.

Please specify:
New ○
Enrolment Re-enrolment ○
Change ○
Termination ○

1: PLAN MEMBER INFORMATION

Member type/Group: 003 Midwives (regular)
Last name:
First name:
SIN

Gender:
Birth date: YYYY - MM - DD
Registered under the Canadian *Indian Act* for provincial tax exemption purposes: ○ Yes ○ No *If yes, please attach a photocopy of the front and back of your status card*

Midwifery Practice Group/Employer:
Practice Partner:
Administrative contact (name and email):

Mobile phone number:
Home mailing address:

City:
Province:
Postal code:
Personal email address:

Reason for plan member information change: -
Date of change: YYYY - MM - DD

For Regular Midwife Members only:
AOM number:
Membership Status: -
Billing number:
AOM registration date: YYYY - MM - DD
Benefits effective date: YYYY - MM - DD

For Salaried/Hourly Midwife Members only:
AOM number:
Employment Status: -
Hours worked per week:
Annual salary:
AOM registration date: YYYY - MM - DD
Benefits effective date: YYYY - MM - DD

For Staff Plan Members only:
Employee number:
Employment Status: -
Hours worked per week:
Annual salary:
Hire date: YYYY - MM - DD
Benefits effective date: YYYY - MM - DD

2: PLAN MEMBER COVERAGE AND FAMILY INFORMATION

Required health coverage: ○ Individual ○ Single parent ○ Couple ○ Family

Required dental coverage: ○ Individual ○ Single parent ○ Couple ○ Family

Reason for coverage change: -

Available Coverage Options Upon enrolment, the participant must choose one of the following coverage options: a) individual coverage, which covers the participant only; b) single-parent coverage, available only for the health and dental insurance plan, which covers the participant and dependent children; c) family coverage, which covers the participant, spouse and dependent children, where applicable.

Do you have a spouse/partner and/or dependants? ○ Yes ○ No

Please list all of your eligible dependants below. For complete information on eligibility requirements for spouses and children, please see Benefits at a Glance.

Spouse/partner ○ Add ○ Delete ○ Change
Last name:
First name:
Spouse/partner's birth date: YYYY - MM - DD
Gender:
Date of cohabitation/marriage: YYYY - MM - DD

Other dependants:	Last name:	First name:	Middle initial:	Date of birth:	Gender:	Student (if 21 years or older):	Disabled:
Add	Child 1			YYYY - MM - DD		○ Yes ○ No	○ Yes ○ No
Add	Child 2			YYYY - MM - DD		○ Yes ○ No	○ Yes ○ No
Add	Child 3			YYYY - MM - DD		○ Yes ○ No	○ Yes ○ No
Add	Child 4			YYYY - MM - DD		○ Yes ○ No	○ Yes ○ No

Do you or your dependants have Health coverage under another insurance plan? ○ Yes ○ No
Name of other carrier:

Do you or your dependants have Dental coverage under another insurance plan? ○ Yes ○ No
Name of other carrier:

You can submit claims under one plan and submit any remaining unpaid amounts to the other plan. Note: Canadian Life and Health Insurance Regulations stipulate:

- A spouse/partner must submit claims to their own plan first.
- Claims for insured children must be first submitted to the plan insuring spouse/partner whose birth date is earlier in the calendar year (regardless of year of birth)

3: OPTIONAL LIFE INSURANCE

Optional Life Insurance is available in units of $10,000 up to $250,000. A completed health questionnaire will be required. Rates are based on your age, gender, and smoker status. Please note, in order to be eligible for non-smoker rates, SSQ Insurance requires that you have not smoked nor vaped (e-cigarettes or similar devices) tobacco nor cannabis products (medicinal and recreational) for the past 12 months.
By checking the non-smoker declaration box below, you (and your spouse, if applicable) are declaring that the following statement is true and complete. You also acknowledge that if you make a false declaration, your coverage may be voided. If non-smoker is not selected, smoker status will be assumed.
"I understand that to be considered a non-smoker, I must not have smoked during the twelve (12) months prior to the application for insurance. I understand that the insurer may periodically require confirmation of non-smoker status; in such case I must be able to meet the requirements in force at that time and return confirmation within 30 days of the insurers request, failing which I will no longer benefit from non-smoker status and the associated reduction in premiums, effective as of the date of the insurer's request"

Participant: Non-smoker ☐
Gender _____
Amount requested _____
Terminate optional life insurance ☐

Spouse: Non-smoker ☐
Gender _____
Amount requested _____
Terminate optional spousal life insurance ☐

4: OPTIONAL INSURANCES

Changes indicated below only apply to any optional (additional) AD&D and/or Critical Illness insurance and will not affect your enrollment in the mandatory insurances (Basic Life, Basic AD&D, Basic Critical Illness). Additional forms are required to apply for optional insurances. Contact the AOM Benefits Trust for more information.

Add (additional forms required):

☐ Optional AD&D ☐ Spousal AD&D ☐ Child AD&D ☐ Optional Critical Illness ☐ Spousal Critical Illness ☐ Child Critical Illness

Terminate:

☐ Optional AD&D ☐ Spousal AD&D ☐ Child AD&D ☐ Optional Critical Illness ☐ Spousal Critical Illness ☐ Child Critical Illness

5: WAIVER OF BENEFITS

You may waive health and dental coverage ONLY if you have comparable coverage through a spouse/partner plan. In the event coverage terminates or reduces at a later date, you may apply for health and dental coverage within 31 days and be automatically reinstated. If you do not apply within 31 days, you and/or your dependants may be required to provide evidence of insurability (i.e. medical statement) and may be denied coverage. To waive coverage, complete the information below and include proof of comparable coverage (receipt or Explanation of Benefits statement) highlighting your existing coverage from your alternative insurance carrier, written documentation from your spouse/partner's employer detailing your current family coverage, OR a copy of your benefit drug card with a recently submitted receipt from your pharmacy, dentist or allied health practitioner. Some midwives may qualify for non-participation; see Factsheet #12 for more information.

I do NOT want (select one OR both):

☐ **Extended Health Care** *(includes prescriptions, travel, paramedical, and medical supplies)*

☐ **Dental Services** *(includes basic and major services and orthodontics)*

Other group insurance company name:

Policy number:

6: BENEFICIARY DESIGNATION FOR LIFE INSURANCE AND AD&D

If you designate a beneficiary who is: a) under the age of majority, or b) mentally incapacitated, you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details. Original beneficiary information will be kept by your plan sponsor/administrator. Where no beneficiary is designated, a benefit will become payable to the member's estate.

☐ I am revoking all prior beneficiaries and appointing the following:

Name your beneficiary or beneficiaries:

Last name:	First name:	Middle initial:	Date of birth:	Gender:	Relationship to plan member:	Percent allocated:
			YYYY - MM - DD			
			YYYY - MM - DD			
			YYYY - MM - DD			
			YYYY - MM - DD			

Total value must equal 100% **TOTAL** 0

I appoint _____ as trustee to receive any amount designated to a beneficiary who is under the age or majority or mentally incapacitated.

In the event the primary beneficiary or beneficiaries predeceases the plan member, the following contingent beneficiary or beneficiaries shall be entitled to the benefits:

Last name:	First name:	Middle initial:	Date of birth:	Gender:	Relationship to plan member:	Percent allocated:
			YYYY - MM - DD			
			YYYY - MM - DD			

*For Quebec residents only: In Quebec, if designation is not indicated, the designation of the legal spouse is irrevocable and the designation of any other beneficiary is revocable.

I wish to make my designation: ◯ Revocable ◯ Irrevocable

7: PLAN MEMBER DECLARATION

I consent to the collection, use and exchange of my personal information by my plan sponsor/administrator, an insurance company, and/or others who require information to administer my group benefits. I authorize these parties to obtain and exchange between them, any information about me, my spouse, and my dependant children to determine benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided from time to time, following the privacy guidelines outlined in the SSQ Insurance policy. I confirm that I have obtained consent from my spouse and any dependant children over the age of majority, to share information as it relates to the plan. In the case of death, I expressly authorize by plan sponsor/administrator, the policyholder, the beneficiary, heir, or liquidator of my estate to provide the insurance companies, when required by the latter, with all the information and authorizations permitting the assessment of the claim and the collection of evidence. I hereby apply for group benefits under my plan sponsor/administrator's plan and authorize any required deductions. I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrollment form will be retained by my plan sponsor/administrator. I hereby confirm the above beneficiary designation, which replaces any previous revocable beneficiary. I reserve the right to change my revocable beneficiary designation at any time.

Plan member signature:

Date signed:
YYYY - MM - DD

Plan sponsor/administrator signature:

Date signed:
YYYY - MM - DD