



GROUP INSURANCE PLAN EMPLOYEE APPLICATION

PLEASE PRINT

For Office Use Only

Firm #:	Certificate #:
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EMPLOYMENT INFORMATION

Contract holder: Association of Ontario Midwives Benefits Trust		Province: Ontario	
Date of Full-Time Employment (D/M/Y):		Occupation:	
Annual Earnings:	# of Hours/Week:	Class:	Effective Date (D/M/Y):
Province of Employment: Ontario			

EMPLOYEE INFORMATION

Last Name:		Birthdate (D/M/Y):	
First Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law (cohabited for at least 12 months)*			
*Date cohabitation began (for common-law relationships) (D/M/Y):			
Smoking Status: <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker		Language Preferences: <input type="checkbox"/> English <input type="checkbox"/> French	
Home Address:			
City:	Province:	Postal Code:	

SPOUSAL INFORMATION

Last Name:		Birthdate (D/M/Y):	
First Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Smoking Status: <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker			

DEPENDENT INFORMATION

Last Name	First Name	Birthdate (D/M/Y)	Gender: M/F	Full-Time Student (age 21-25)	Disabled Dependent (over age 21)
Child			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
Child			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>

BENEFICIARY DESIGNATION FOR OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the Policy. Failing such designation, all benefits will be paid to the Estate of the Insured Person.

I hereby name the following revocable beneficiary (Irrevocable in the province of Quebec) for any Life and/or Accidental Death and Dismemberment Insurance benefits payable as a result of my participation in this plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid.

Please Note: In the province of Quebec, if you have designated your married or civil union spouse as beneficiary, the designation will be considered irrevocable unless you check here: Revocable.

I hereby make the beneficiary designated below. I may elect to change this beneficiary designation at any time.

Beneficiary's Full Name:	Relationship to You:
Trustee's Name (if applicable):	Relationship to Minor Beneficiary:

OPTIONAL BENEFIT AMOUNT SELECTION

PLEASE NOTE: The following section only applies to optional coverages and does not need to be completed for coverage under the standard (i.e. non-optional) group benefits. For further information on available optional benefits, please contact your plan administrator

Please enter below the amount of coverage you would like to purchase, in increments of \$5,000 (\$10,000 min. for adults)

B	Optional Accidental Death & Dismemberment		
	<input type="checkbox"/> Coverage	\$	<input type="checkbox"/> Employee Only Plan
	<input type="checkbox"/> Coverage	\$	<input type="checkbox"/> Spouse Plan
	<input type="checkbox"/> Coverage	\$	<input type="checkbox"/> Children's Plan

C	Optional Critical Illness		
	Guaranteed Issue Up to \$25,000, no medical required. Eligible if applying between August 1 - 31, 2017.		Evidence of Insurability** Up to \$150,000 per person combined with basic (plan members receive \$10,000 basic coverage) and Guaranteed Issue
	<input type="checkbox"/> Employee Coverage	\$	<input type="checkbox"/> Smoker or <input type="checkbox"/> Non-Smoker
	<input type="checkbox"/> Spousal Coverage	\$	<input type="checkbox"/> Smoker or <input type="checkbox"/> Non-Smoker
	<input type="checkbox"/> Dependent Children	<input type="checkbox"/> \$5,000 or <input type="checkbox"/> \$10,000 (Only available in conjunction with the enrollment of the employee and/or spouse)	
	<i>**WILL REQUIRE COMPLETION OF THE GROUP CRITICAL ILLNESS STATEMENT OF HEALTH</i>		

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I hereby apply for coverage under the Group Insurance Plan, underwritten by Chubb Life Insurance Company of Canada, for which I am or may become eligible and authorize any required payroll deductions for administration of my benefits. I certify that the information provided herein is true, accurate and complete; and that I have no other coverage under this plan and have not applied for any.

Please sign here:

Employee's Signature

Date (D/M/Y)