GROUP INSURANCE PLAN EMPLOYEE APPLICATION

PLEASE PRINT

For Office Use Only

Firm #:	Certificate #:

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: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Common Law (cohabited for at least 12 months)*		
*Date cohabitation began (for common-law relationships) (D/M/Y):		
Smoking Status: ☐ Smoker ☐ Non-Smoker	Language Preferences: ☐ English ☐ French	
Home Address:		
City:	Province:	Postal Code:

SPOUSAL INFORMATION

Last Name:	Birthdate (D/M/Y):
First Name:	Gender: ☐ Male ☐ Female
Smoking Status: ☐ Smoker ☐ 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			☐ M ☐ F	☐	☐
Child			☐ M ☐ F	☐	☐
Child			☐ M ☐ F	☐	☐

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**		
	☐ **Coverage**	**$**	☐ **Employee Only Plan**
	☐ **Coverage**	**$**	☐ **Spouse Plan**
	☐ **Coverage**	**$**	☐ **Children's Plan**

C	**Optional Critical Illness**			
		Guaranteed Issue Up to $25,000, no medical required. Eligible if applying within 30 days of "date of eligibility" for benefits (3 months of employment).	**Evidence of Insurability**** Up to $150,000 per person combined with basic (plan members receive $10,000 basic coverage) and Guaranteed Issue	
	☐ **Employee Coverage**	**$**	**$**	☐ **Smoker or** ☐ **Non-Smoker**
	☐ **Spousal Coverage**	**$**	**$**	☐ **Smoker or** ☐ **Non-Smoker**
	☐ **Dependent Children**	☐ $5,000 **or** ☐ $10,000 (Only available in conjunction with the enrollment of the employee and/or spouse)		
		***WILL REQUIRE COMPLETION OF THE GROUP CRITICAL ILLNESS STATEMENT OF HEALTH*		

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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)