CHUBB®

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 Registration (D/M/Y):	**Occupation: Midwife**	
Annual Earnings:	**Class: C**	**Effective Date (D/M/Y):**
Province of Employment: Ontario		

MEMBER 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**	**$**	☐ **Member Only Plan**
	☐ **Coverage**	**$**	☐ **Spouse Plan**
	☐ **Coverage**	**$**	☐ **Children's Plan**

C	**Optional Critical Illness**			
		Guaranteed Issue Up to $25,000, no medical required.	**Evidence of Insurability**** Up to $150,000 per person combined with basic (plan members receive $10,000 basic coverage) and Guaranteed Issue	
	☐ **Member Coverage**	**$**	**$**	☐ **Smoker or** ☐ **Non-Smoker**
	☐ **Spousal Coverage**	**$**	**$**	☐ **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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To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

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) _____